

087143

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 3 6 9

REG. NO.

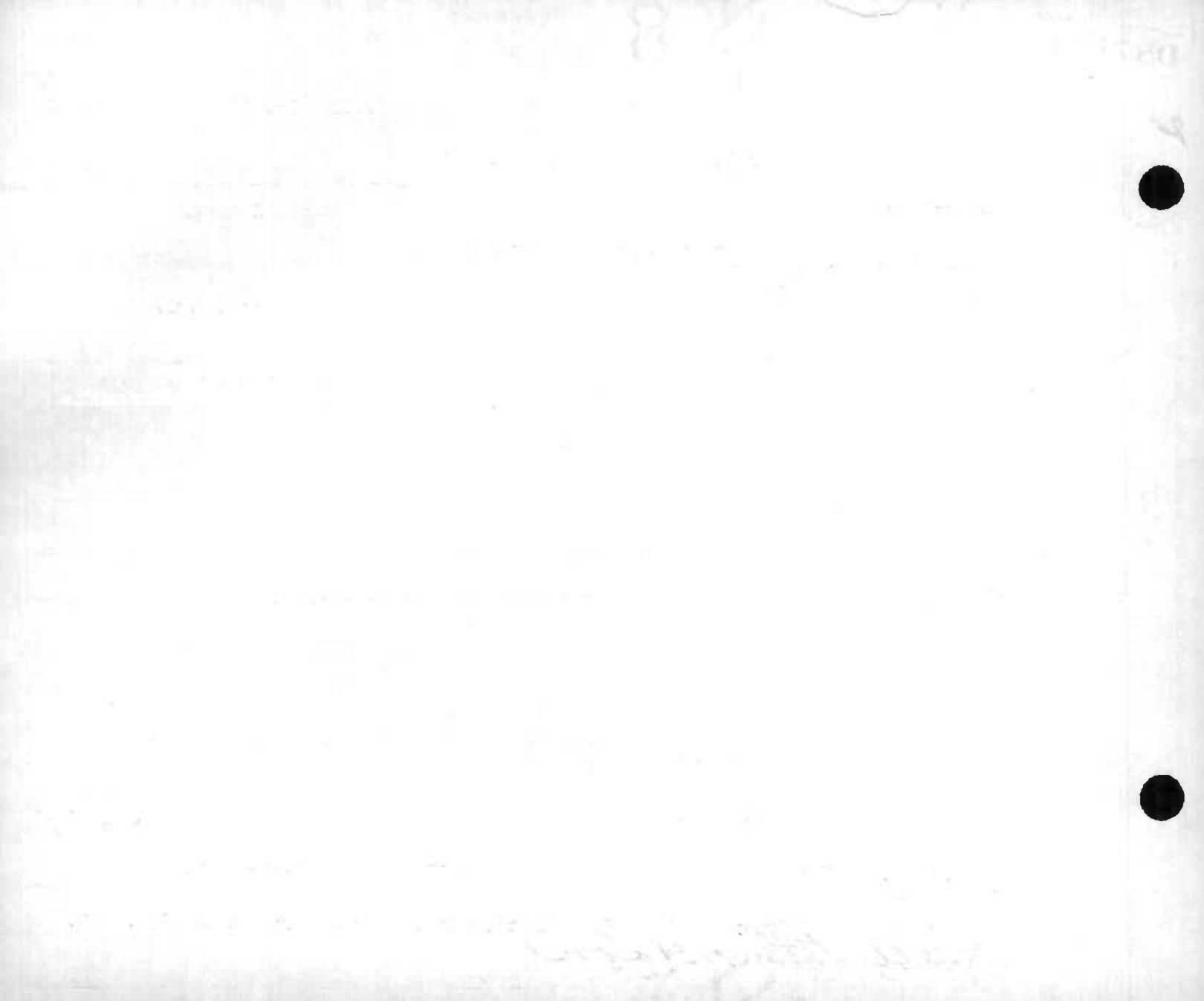
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST OSCAR A AUBIN			2a. DATE OF DEATH MONTH DAY YEAR MARCH 16, 1985		2b. HOUR 8:20A M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 7, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.			
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER PERRY POINT MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Insurance	
13a. STATE Florida		13b. COUNTY Broward		13c. CITY OR TOWN Hollywood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1127 North Lake Drive 34999	
14. FATHER'S NAME FIRST MIDDLE LAST Oscar A. Aubin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janet Myers			ADDRESS Pompano Beach, Fl.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 942-1945		17. INFORMANT Mrs. Janet Thomas		2510 NE 10th Court			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JUNE 18, 1980, to MARCH 16, 1985, that (I) (we) last saw the deceased alive on MARCH 16, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jean T. Pouyes MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/16/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEAN T. POUYES				22e. ADDRESS VA MEDICAL CENTER PERRY POINT, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 19, 1985		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Prince Geo. MD.			
24. FUNERAL DIRECTOR Patterson Funeral Home Perryville MD				25a. DATE REC'D. BY REGISTRAR MAR 28 1985		25b. REGISTRAR'S SIGNATURE R. Davidson-Rindone			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within one hour after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



085141

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 0 8 3 7 0
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grace Marie Baker			2a. DATE OF DEATH MONTH DAY YEAR March 19, 1985		2b. HOUR 8:30 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 1, 1915	6. AGE (IN YEARS, LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chesapeake City, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.		
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Secretary	12b. KIND OF BUSINESS OR INDUSTRY Supply	
13a. STATE Md.		13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 21921 135 Maffitt Street
14. FATHER'S NAME FIRST MIDDLE LAST W. Herbert Baker			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Reba Curtis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 221-03-6801	17. INFORMANT ADDRESS Orangevale, Ca. 1 Wm. H. Baker, Jr. 9530 Golden Dr.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
(b) _____ DUE TO, OR AS A CONSEQUENCE OF		
(c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.
Mixed connective tissue disease with esophageal dilation and reflux. Bronchopneumonia.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/27</u> , 19 <u>84</u> , to <u>3/19</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/19</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Edgar E. Beck</u>	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3-19-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Edgar E. Beck III</u>		22e. ADDRESS <u>Union Hospital, Elkton, MD, 21921</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>3-23-85</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Chesapeake City Cecil, Md.</u>
24. FUNERAL DIRECTOR NAME <u>B. Beck</u> ADDRESS <u>Elkton, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 21 1985</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

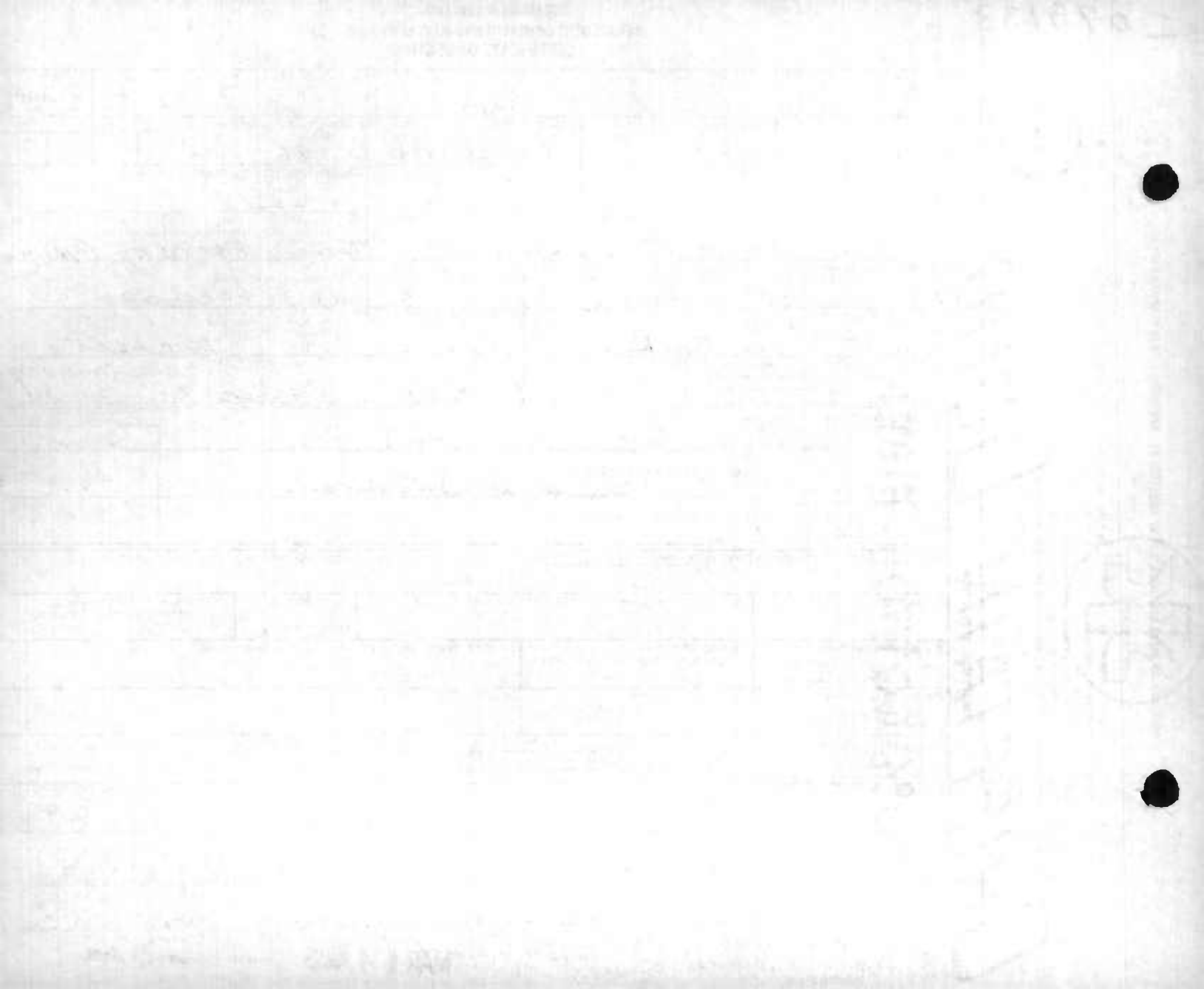
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William M Barker		2a. DATE OF DEATH MONTH DAY YEAR 3 12 85		2b. HOUR 8:43 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6 26 1898	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
10. CITY OR TOWN OF DEATH Rising Sun		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2747 TOME HWY.		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tobacco Farmer		12b. KIND OF BUSINESS OR INDUSTRY Agricult.			
13a. STATE N.C.		13b. COUNTY ASHE		13c. CITY OR TOWN LANSING	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RD 3, PO Box 50			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Barker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Lambert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 238-24-0029		17. INFORMANT ADDRESS 2747 TOME HWY. MILLARD BARKER RISING SUN MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart Failure DUE TO, OR AS A CONSEQUENCE OF: (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks. 5 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cirrhosis of liver					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-1 1983, to 3-12 1985, that (I) (we) last saw the deceased alive on 3-12 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Neil Taylor MD		DEGREE MD		22c. DATE SIGNED 3-12-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor MD		22e. ADDRESS Rising Sun, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-16-85		23c. NAME OF CEMETERY OR CREMATORY BARKER-McNEILL CEM.	
23d. LOCATION CITY OR TOWN COUNTY STATE LANSING ASHE N.C.					
24. FUNERAL DIRECTOR NAME Richard L. Gooche		ADDRESS Rising Sun, MD		25a. DATE REC'D. BY REGISTRAR MAR 14 1985	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandey					



4098217

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8508372

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROBERT I BARNES			2a. DATE OF DEATH MONTH DAY YEAR MARCH 25, 1985			2b. HOUR 11:26 PM			
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 12 24		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH PERRY POINT, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plasterer		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Pa.		13b. COUNTY Chester		13c. CITY OR TOWN Oxford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 440 Broad St 19363	
14. FATHER'S NAME FIRST MIDDLE LAST Ocil W- Barnes					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Crosten				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS James L. Co. Summer New Cape R.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC AND RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) HEPATOCELLULAR OBSTRUCTIVE LIVER DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ALCOHOLIC CIRRHOSIS AND HEPATITIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a CHRONIC OBSTRUCTIVE PULMONARY DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from MARCH 19, 1985, to MARCH 25, 1985, that (we) last saw the deceased alive on MARCH 25, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death.									
22b. SIGNATURE Glendon Rayson				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENDON RAYSON, M.D.				22e. ADDRESS VA MEDICAL CENTER, PERRY POINT, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/26/85		23c. NAME OF CEMETERY OR CREMATORY Creston & Ferris		23d. LOCATION CITY OR TOWN COUNTY STATE Waverly Chester Pa.			
24. FUNERAL DIRECTOR NAME Richard L. Goodie, President, Sum. Ind. DOUGLAS WOODWORTH FUNERAL HOME, OXFORD, PA				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE APR 03 1985			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Stella	MIDDLE Aline	LAST Bell	2a. DATE OF DEATH MONTH DAY YEAR March 4, 1985		2b. HOUR 7:40 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 9, 1928		6. AGE (IN YEARS (LAST BIRTHDAY)) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Durmond, N. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 316 Friendship Road 21921	
14. FATHER'S NAME FIRST MIDDLE LAST Tyree Ross				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Shoffner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. no		17. INFORMANT ADDRESS Wm. M. Bell 316 Friendship Rd. Elkton, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Removal failure.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

CHF. pneumonia. Respiratory failure.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Hypertension. Diabetes mellitus

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 5/16 1977 to 3/4 1985, that (we) lost saw the deceased alive on 3/3 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.							
22b. SIGNATURE Jui Chih Hsu. MD				DEGREE MD		22c. DATE SIGNED 3-4-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jui Chih Hsu. MD				22e. ADDRESS 223 West Mac St, E. Md 21921			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-7-85		23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		23d. LOCATION Cecil MD.	
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24. FUNERAL DIRECTOR NAME Gee Funeral Home P.A.		ADDRESS Elkton, Md.		25a. DATE REC'D. BY REGISTRAR MAR 06 1985		25b. REGISTRAR'S SIGNATURE J. H. Hsu	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

2005



078088

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

8 5 0 8 3 7 4

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Florence M. Biddle</i>			2a. DATE OF DEATH MONTH <i>3</i> DAY <i>8</i> YEAR <i>85</i>		2b. HOUR <i>2:30 PM</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>NOVEMBER</i> DAY <i>4</i> YEAR <i>1898</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil Co.</i> MD.	
10. CITY OR TOWN OF DEATH <i>ELKTON</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Cecil</i>	13c. CITY OR TOWN <i>Elkton</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <i>Charles</i> MIDDLE <i>-</i> LAST <i>Johnson</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Ellen</i> MIDDLE <i>V.</i> LAST <i>Gaither</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>217-36-3100</i>		17. INFORMANT ADDRESS <i>Mrs. Margaret Louise Ferguson, Elkton, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRONCHIO PNEUMONIA</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CONGESTIVE HEART FAILURE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>3-7</i> 19 <i>85</i> , to <i>3-8</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3-8</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Rolando Rajera</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>3-9-85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Rolando Rajera MD</i>		22e. ADDRESS <i>ELKTON, MD 21921</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3-12-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gilpin Manor Memorial Park, Elkton, Md.</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Elkton, Md. 21921</i>		24. FUNERAL DIRECTOR NAME <i>Ralph E. Hicks</i> ADDRESS <i>HICKS HOME FOR FUNERALS, ELKTON, MD 21921</i>			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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9

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

079100

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) William Thomas Bowser			2a. DATE OF DEATH MONTH DAY YEAR March 7, 1985			2b. HOUR 8:00P M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3- 14 - 28		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. CITY OR TOWN Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Roland Hardy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Bowser			13e. STREET ADDRESS / ZIP CODE 431 Baltimore, St./21001			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea		17. INFORMANT Mary Bowser		ADDRESS 431 Blto., St., Aberdeen, MD, 21001		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of esophagus with metastasis									
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic pancreatitis									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from January 18, 19 85 to March 7, 19 85 , that (X) (we) lost saw the deceased alive on March 7, 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Prem Lal			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Prem Lal, M.D.			22e. ADDRESS VA Medical Center, Perry Point, MD 21902						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 12, 1985		23c. NAME OF CEMETERY OR CREMATORY Union United		23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen, Harford, Maryland		
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, Aberdeen, Md. 21001-3399			25a. DATE REC'D. BY REGISTRAR MAR 13 1985			25b. REGISTRAR'S SIGNATURE one Davidson-Randall			

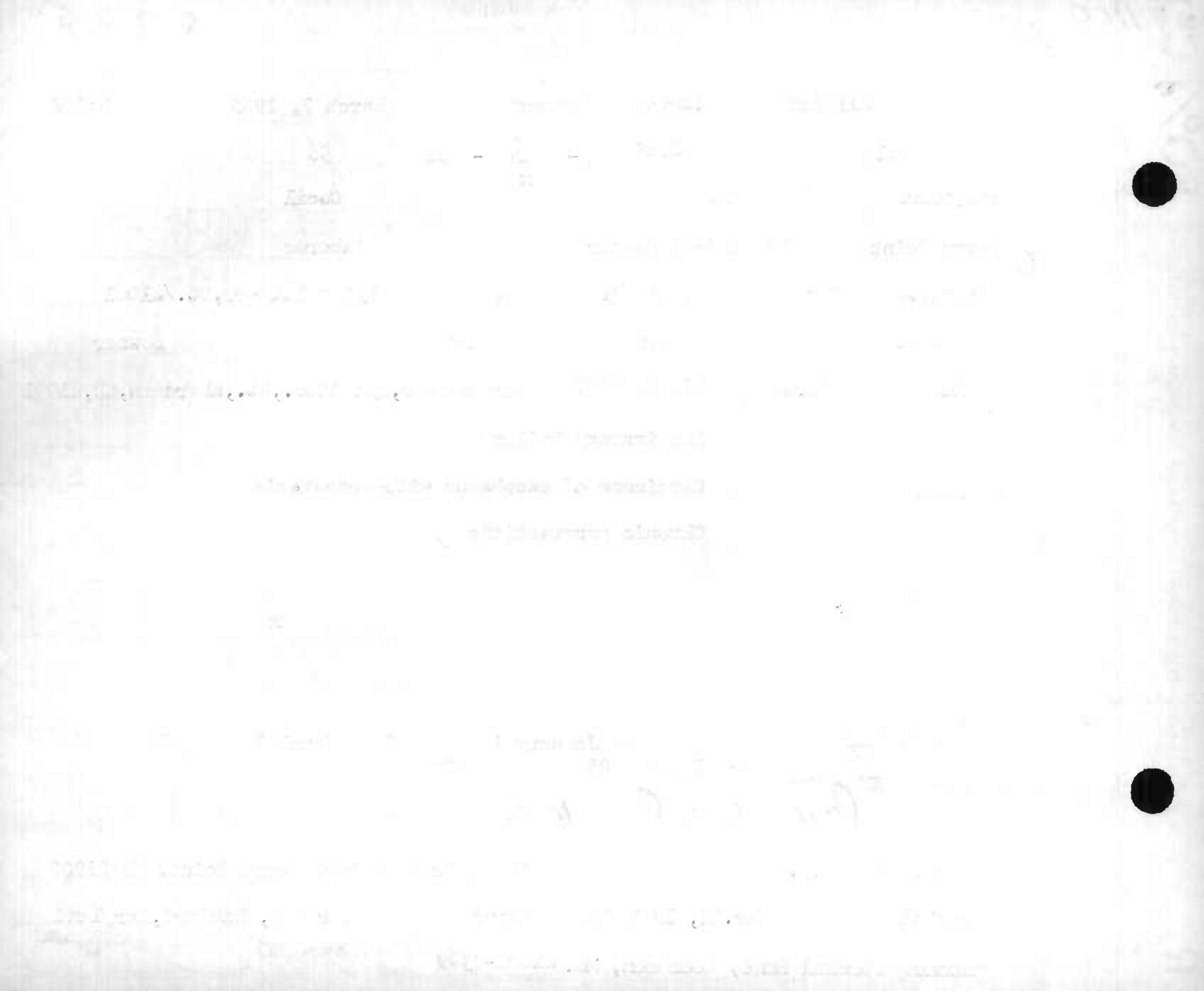
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
JAY HOWARD BRICE SR.					FEBRUARY 27, 1985				
3. SEX					4. RACE				
MALE					CAUC.				
5. DATE OF BIRTH					6. AGE				
SEPT. 26, 1916					68				
7a. BIRTHPLACE					7b. CITIZEN OF WHAT COUNTRY?				
WILMINGTON, DEL.					U.S.A.				
8. MARRIED					9. BALTIMORE CITY OR COUNTY OF DEATH				
NEVER MARRIED					CECIL				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				
WARWICK					GRAHAM'S NURSING HOME				
12a. USUAL OCCUPATION					12b. KIND OF BUSINESS OR INDUSTRY				
TRUCKDRIVER					TEAMSTERS				
13a. STATE					13b. COUNTY				
MARYLAND					CECIL				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
RALPH					MYRTLE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.				
YES					222-09-2987				
17. INFORMANT					ADDRESS				
DORIS MATTHEWS sister					same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
previous CVA with paralysis, recurrent urinary tract infection.									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
YES					YES				
21a. ACCIDENT WAS UNDERLYING					21b. TIME OF INJURY				
OR CONTRIBUTING CAUSE OF DEATH					HOUR A.M. MONTH DAY YEAR				
(IF EITHER, NOTIFY MEDICAL EXAMINER)					P.M. 19				
21d. INJURY OCCURRED					21e. PLACE OF INJURY				
WHILE AT WORK					AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21f. LOCATION					CITY OR TOWN				
STREET					COUNTY				
STATE					19				
22a. I certify that (I) (the hospital) attended the deceased from Feb 19 84 to 27 Feb 19 85, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
Wallace Obenshain M.D.					27 Feb 85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Wallace Obenshain, M.D.					CECIL KENT HEALTH SERVICES CECILTON, MD				
23a. BURIAL, CREMATION, REMOVAL					23b. DATE				
CREMATION					MARCH 5, 1985				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION				
SILVERBROOK CREM.					WILMINGTON, N.C. DEL.				
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR				
NAME					25b. REGISTRAR'S SIGNATURE				
FELLOWS F.H. 226 E. MAIN ST. CECILTON, MD 21033					MAR 1 4 1985 Julia Davidson-Randall				

Arteriosclerotic heart disease

previous CVA with paralysis, recurrent urinary tract infection.

Feb 85 26 Feb 85 27 Feb 85 28 Feb 85

Wallace O'Brien, M.D.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 3 7 7

FOR
1 - STATE
REGISTRAR

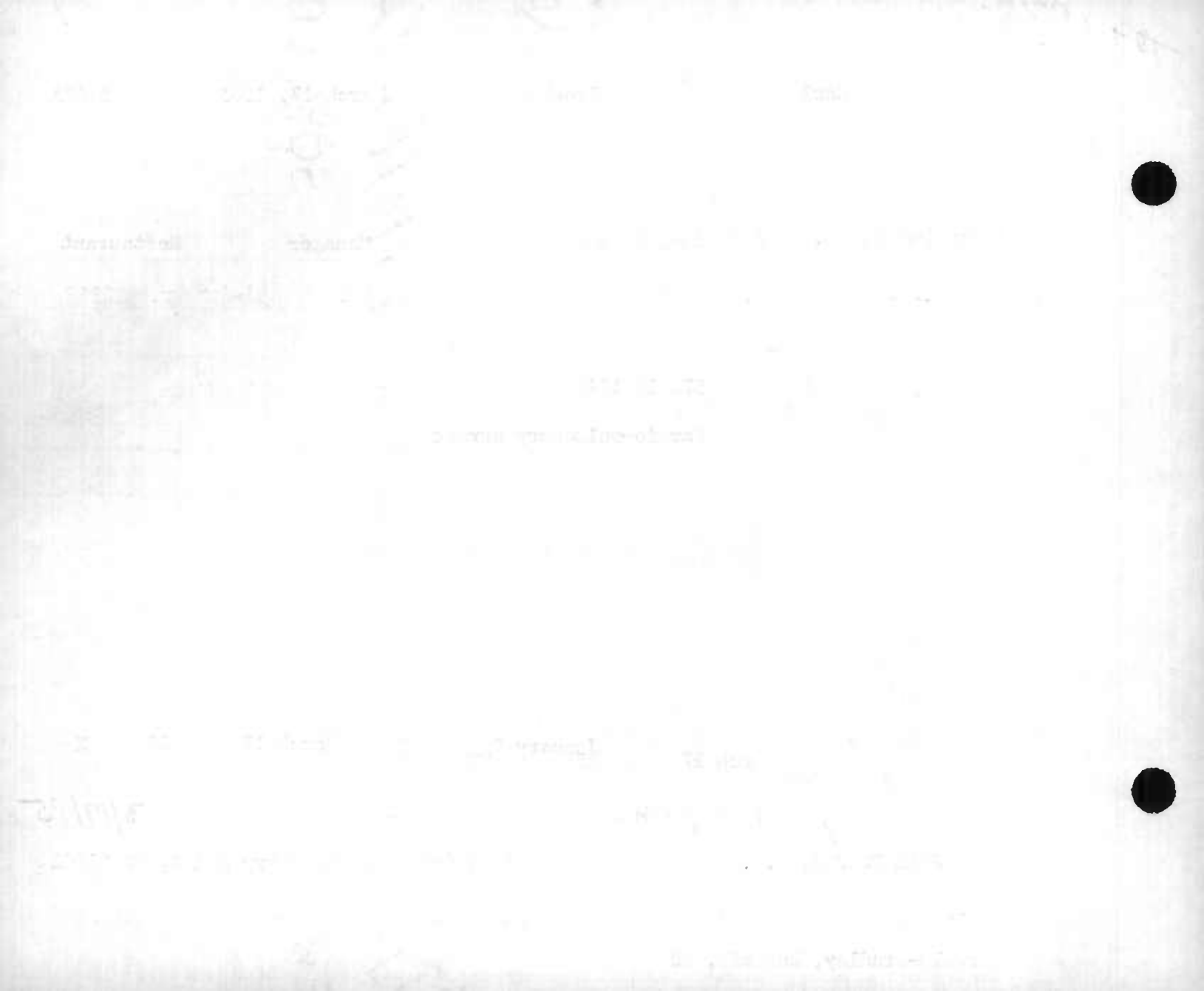
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Carl Francis Brooks			2a. DATE OF DEATH MONTH DAY YEAR March 17, 1985		2b. HOUR DAY MIN. 2:42A		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 20, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 64 yrs. YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cumberland, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10. CITY OR TOWN OF DEATH Perry Point, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NON-RESIDENT, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Merrill A. Brooks				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Teresa A. Brooks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 578 18 1968		17. INFORMANT ADDRESS Suzanne J. Brooks (Wife) (Same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from January 3, 1985 , to March 17, 1985 , that (X) (we) lost saw the deceased alive on March 17, 1985 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.							
22b. SIGNATURE <i>Jeane Pouyes</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/17/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEAN POUYES, M.D.				22e. ADDRESS VA Medical Center, Perry Point, MD 21902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/18/1985		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Brooks-Bradley, Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR MAR 18 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



082067

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 3 7 8

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ronda Jones Campbell			2a. DATE OF DEATH MONTH DAY YEAR March 2, 1985			2b. HOUR 1930 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 12 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lansing N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self employed		12b. KIND OF BUSINESS OR INDUSTRY Store Owner	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. CITY OR TOWN Cecil		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 102 Decker St. 21921		
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Campbell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Mae Osborne						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 192-12-5738		17. INFORMANT Eva Campbell		17. ADDRESS 102 Decker St. Elkton, Md. 21921			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>And myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>36 hrs</u>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Parkinsons Disease, Hyperglycemia, Gastritis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>75</u> , to <u>March 2</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>March 2</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Charles H. Hensgen</u>				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN				22c. DATE SIGNED 4/1/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Hensgen				22e. ADDRESS 3 Mauldin Ave. North East, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-5-85		23c. NAME OF CEMETERY OR CREMATORY North East Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE North East Cecil Md.			
24. FUNERAL DIRECTOR Crouch Funeral Home North East, Md.				25a. DATE REC'D. BY REGISTRAR MAR 6 1985		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 25M
(VRA 15, 4) 1/79

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Central American
and Caribbean

Backbone of the

March 1st

Change in

100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 3 7 9

FOR
1- STATE
REGISTRAR

REG. NO.

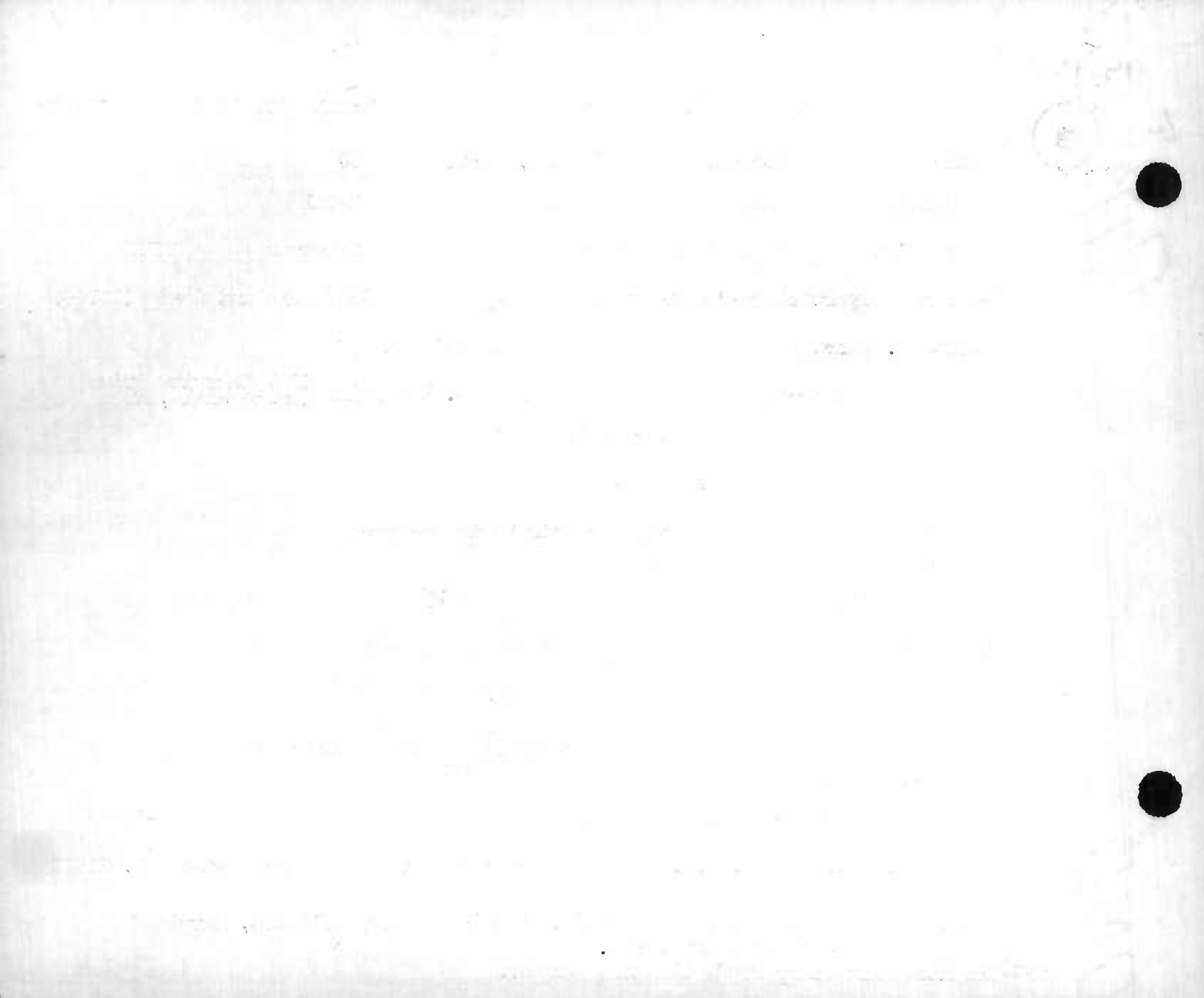
087058

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William M. Carroll			2a. DATE OF DEATH MONTH DAY YEAR March 13, 1985			2b. HOUR 11:20PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 13, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD	
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Surveyor		12b. KIND OF BUSINESS OR INDUSTRY PEPCO	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Prince George's		13c. CITY OR TOWN Suitland	
14. FATHER'S NAME FIRST MIDDLE LAST George T. Carroll				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Padgett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1942-1943		17. INFORMANT Betty A. Bragunier		ADDRESS 4207 Lakeview Drive Temple Hills, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration DUE TO, OR AS A CONSEQUENCE OF (c) Chronic organic brain syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from February 17, 19 83, to March 13, 19 85, that (X) (we) lost saw the deceased alive on March 13, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Glendon E. Rayson				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-13-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENDON E. RAYSON, M.D.				22e. ADDRESS VA Medical Center, Perry Point, MD. 21902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 16, 1985		23c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, Maryland	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR MAR 22 1985			
25b. REGISTRAR'S SIGNATURE Lee Davidson-Randall							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.



092030

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) MILDRED J. CARTY			2a. DATE OF DEATH MONTH DAY YEAR MAR 22 1985			2b. HOUR 4:30AM			
3 SEX Female		4 RACE W		5. DATE OF BIRTH MONTH DAY YEAR SEPT 29, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 78		7. BALTIMORE CITY OR COUNTY OF DEATH Cecil County	
7a. BIRTHPLACE (STATE OR FOREIGN) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OR PRINT) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Housewife	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE, GIVE STREET ADDRESS) Union Hospital		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS - ZIP CODE #11 Holly Square - 2109			
14. FATHER'S NAME (TYPE OR PRINT) George Tomlinson		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) Ada Vinson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 221-50-6784		17. INFORMANT NAME LAST Ralph B. Carty, Jr. - Middlebrook, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (b) _____ DUE TO, OR AS A CONSEQUENCE OF: (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND IN THE
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 6/5, 1979 to 3/22, 1985 , that (I) (we) lost saw the deceased alive on 3/22, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Kenneth Lewis, MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/25/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth Lewis M.D.			22e. ADDRESS 12 Pennington M. d d letam de						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar 26, 1985		23c. NAME OF CEMETERY OR CREMATORY Edgemoor Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Springer Kent - Del.		
24. FUNERAL DIRECTOR Robert C. Hutchinson - Middlebrook, Md.			25. DATE REC'D. BY REGISTRAR MAR 28 1985		26. REGISTRAR'S SIGNATURE James Harrison-Henderson				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove completed pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified directly.



WINTERED

IN PARTY

18

SETTLED

X

X

X



1873

081027

5/21/85 Item #13

L.J

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85

08381

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LUKE Wayne Chadwick			2a. DATE OF DEATH MONTH DAY YEAR 3/13/85			2b. HOUR 05:30 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 13, 1985		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 2 08	
7a. BIRTHPLACE (STATE OR FOREIGN) Elkton, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Elkton-Md		13b. COUNTY Elkton		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John T. Chadwick		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Evan s					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Elkton, Md. John. T. Chadwick 119 Providence Rd/			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

7651
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Prematurity

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
19a I certify that (I) (this hospital) attended the deceased from 3/13 , 19 85 , to 3/13 , 19 85 , that (I) (we) last saw the deceased alive on 3/13 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							

22a. SIGNATURE Melencia Ventura		DEGREE MD		22c. DATE SIGNED 3-13-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melencia Ventura MD		22e. ADDRESS Elkton, Md			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-16-85		23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Elkton Cecil Md.	
24. FUNERAL DIRECTOR NAME David M. S. ADDRESS Elkton, Md		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John T. Chadwick			

CHICAGO

1892

Thompson

1892

8 5 0 8 3 8 2

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST DAVID		MIDDLE C.		LAST CHESTER		2a. DATE OF DEATH		MONTH MARCH		DAY 16,		YEAR 1985		2b. HOUR a.m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH FEBRUARY DAY 21, YEAR 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.											
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital															
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Boiler Technician																12b. KIND OF BUSINESS OR INDUSTRY University of Delaware	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE Delaware		13b. COUNTY New Castle		13c. CITY OR TOWN Newark		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5 Lincoln Drive, 19711									
14. FATHER'S NAME FIRST Granville MIDDLE - LAST Chester						15. MOTHER'S MAIDEN NAME FIRST Patty MIDDLE - LAST Evans											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 232-16-9062				17. INFORMANT ADDRESS Mrs. Aughtha Chbster, Newark, Del. 19311									

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) <u>BRONCHOPNEUMONIA</u>	
	DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA OF THE LUNGS</u>	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING: <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY <table border="1"> <tr> <td>HOUR</td> <td>A.M.</td> <td>MONTH</td> <td>DAY</td> <td>YEAR</td> </tr> <tr> <td></td> <td>P.M.</td> <td></td> <td></td> <td>19</td> </tr> </table>	HOUR	A.M.	MONTH	DAY	YEAR		P.M.			19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
HOUR	A.M.	MONTH	DAY	YEAR								
	P.M.			19								

MEDICAL	21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION		
	WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		STREET	CITY OR TOWN	COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 3/5, 1985, to 3-16, 1985, that (I) (we) lost
saw the deceased alive on 3-15, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

27b. SIGNATURE <i>Sylvia Knight</i>	DEGREE	ATTENDING PHYSICIAN	<input checked="" type="checkbox"/> MEDICAL DIRECTOR	STAFF PHYSICIAN <input type="checkbox"/>	27c. DATE SIGNED 3-18-85
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22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Rolando A. Najera, M.D.	105 E. Main Street, Elkton, Md. 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-20-85	23c. NAME OF CEMETERY OR CREMATORY Cherry Hill Methodist Cemetery	23d. LOCATION CITY OR TOWN Cherry Hill, Md. COUNTY STATE
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24 FUNERAL DIRECTOR <i>Harold E. Hicks</i> HICKS HOME FOR FUNERALS, ELKTON, MD. 21921	25a DATE REC'D. BY REGISTRAR MAR 22 1985	25b REGISTRAR'S SIGNATURE <i>Davidson-Pandey</i>
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MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

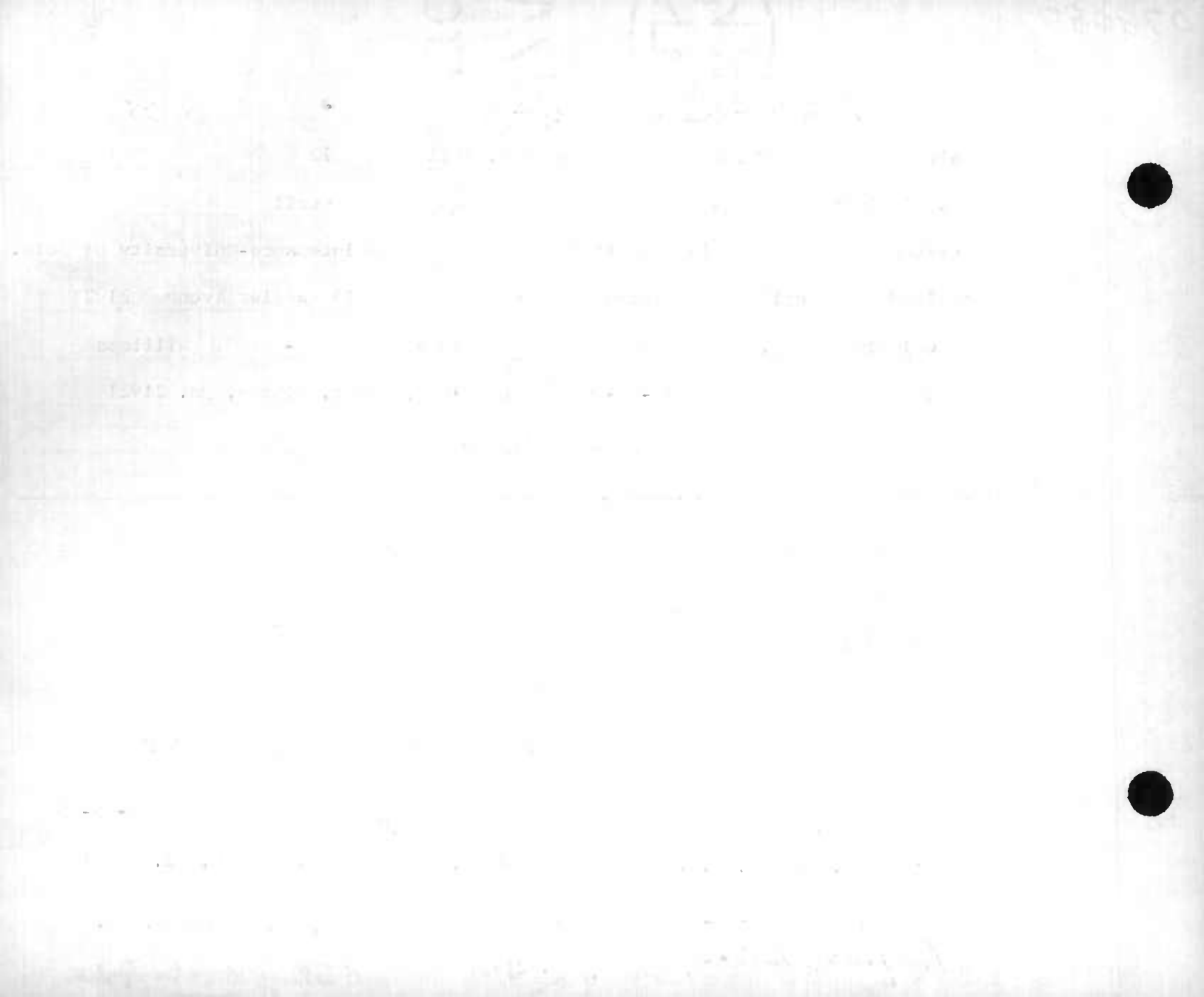
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VERMAN L. CLAY		2a. DATE OF DEATH MONTH DAY YEAR 3 14 85		2b. HOUR 2:50 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 6, 1912	
6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		8. CITIZEN OF WHAT COUNTRY? USA	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		10. CITIZEN OF WHAT COUNTRY? USA		11. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
12. CITY OR TOWN OF DEATH Elkton		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Street Hospital		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance-University of Dela.	
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Maryland		15b. COUNTY Cecil		15c. CITY OR TOWN Elkton	
16. FATHER'S NAME FIRST MIDDLE LAST Benjamin H. Clay		16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Orpha Williams		17. STREET ADDRESS / ZIP CODE 15 Saddler Avenue 21921	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		18. SOCIAL SECURITY NO. 234-12-0406		19. INFORMANT ADDRESS Valerie Y. Wyant, Elkton, Md. 21921	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF (b) Smoking DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21b. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-13 , 19 85 , to 3-14 , 19 85 , that (I) (we) lost saw the deceased alive on 3-14 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard S. Ackart		DEGREE MD		22c. DATE SIGNED 3-15-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard S. Ackart, M.D.		22e. ADDRESS 221 E. Main Street, Elkton, Md. 21921			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-15-85		23c. NAME OF CEMETERY OR CREMATORY CRATIN & FERRIS CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE WEST CHESTER, PA.		24. FUNERAL DIRECTOR Hicks for Funerals, Elkton, MD. 21921			
25a. DATE REC'D. BY REGISTRAR MAR 18 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 3 8 4

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mildred D. Cleaves			2a. DATE OF DEATH MONTH DAY YEAR March 28, 1985			2b. HOUR 7A M					
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Nov 15, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH cecil MD.					
10. CITY OR TOWN OF DEATH Rising Sun		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nrsng Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY Printing			
13a. STATE Del.			13b. COUNTY New Castle		13c. CITY OR TOWN Newark		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 27 Mingail Dr. 29999		
14. FATHER'S NAME FIRST MIDDLE LAST Henry - Cleaves				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora - WANICK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. —		17. INFORMANT ADUVAI Cleaves				ADDRESS 27 Mingail Dr. Newark De. 19713	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(b) dorsal kyphosis + osteoporosis

DUE TO, OR AS A CONSEQUENCE OF

(c) arteriosclerotic heart disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

arteriosclerotic heart disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-14-85 to 3-28-85, that (I) (we) last saw the deceased alive on 3-14-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert L. Smith MD				DEGREE		22c. DATE SIGNED 3-28-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert L. Smith, MD				22e. ADDRESS 5865 Telegraph Rd, Elkton, Md 21924			

23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE 3/30/85		23c. NAME OF CEMETERY OR CREMATORY Elkton Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Elkton Cecil Md.	
24. FUNERAL DIRECTOR NAME Donald M. Gee				25a. DATE REC'D. BY REGISTRAR APR 1 - 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson	

1
1000

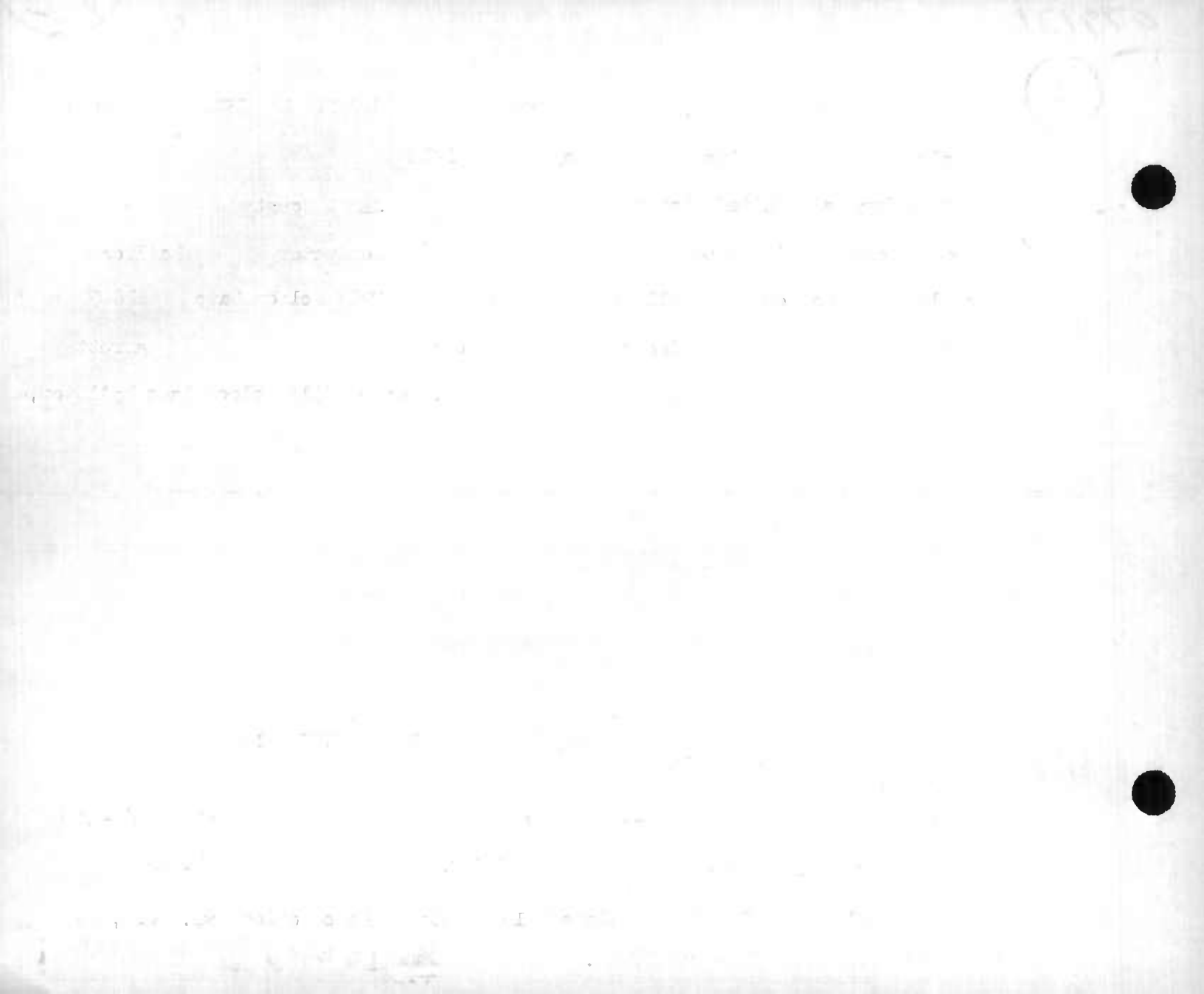
X



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR			
ROBERT		E.		COOPER		MARCH				12,		1985		4:00A		M					
3. SEX		4. RACE		5. DATE OF BIRTH		MONTH		DAY		YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.					
Male		White		May		6		1916		68		YRS.		MONTHS		DAYS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Pennsylvania		United States						CECIL County MD.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Perry Point		VA MEDICAL CENTER PERRY POINT MD										Conductor		Railroad							
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE													
Maryland		Harford		Fallston		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2915 Nelson Lane		21047											
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																	
FIRST				MIDDLE				FIRST				MIDDLE				LAST					
Curvin				Cooper				Rose				Barrett									
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT													
Yes				WW 2				214 18 9573				Evelyn R. Cooper 2915 Nelson Lane Fallston, MD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																					
PART I. DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) CARDIAC ARREST																					
DUE TO, OR AS A CONSEQUENCE OF																					
(b)																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> (AT WORK) (AT WORK)				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 12, 19 83, to MARCH 12, 19 85, that (I) (we) last saw the deceased alive on MARCH 12, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED									
CHRISTOPHER BERCHELMANN				MD.								3/12/85									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS																	
CHRISTOPHER BERCHELMANN				VA MEDICAL CENTER PERRY POINT, MD																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial				3/15/85				Slateville Cemetery				Peachbottom Twp. York, PA									
24. FUNERAL DIRECTOR														25a. DATE REC'D. BY REGISTRAR							
HARKINS FUNERAL HOME - DELTA, PA.														MAR 15 1985							



087093

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5

0 8 3 8 6

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Jerry L. Crouse			3/ 17/ 19 85			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	2d. HOUR	
Male	White	NOV. 5, 1954	30 YRS.			3/ 17/ 19 85	2:21 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania		USA				Cecil County, MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Elkton		Union Hospital			Truck Driver-Augustine Stables			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland			Cecil		Elkton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
Martin A. Crouse			Evelyn - Edwards		3813 Blue Ball Road . 21921			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No			218-68-7740		Mrs. Janice J. Crouse, Elkton, Md. 21921			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:30 PM 3/17/ 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (ATHOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3069 Telegraph Rd., Elkton, Cecil Co. Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Thomas D. Smith, M.D.			M.D. Dep. Chief			3/17/85		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Thomas D. Smith, M.D.			111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			3-21-85		Cherry Hill Methodist Cemetery, Cherry Hill, Md.			
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
HICKS HOME FOR FUNERALS, ELKTON, MD. 21921			MAR 22 1985			John Davidson-Randall		

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DHMH - 17
(VR A15 ME (5))07/84
25M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 3 8 7

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elbert H. Davis			2a. DATE OF DEATH MONTH DAY YEAR 3/10/85		2b. HOUR 1347 M	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR May 10, 1910		
6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.		10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13b. STATE Delaware		13c. COUNTY N.C.		13d. CITY OR TOWN Middletown		
14. FATHER'S NAME FIRST MIDDLE LAST Steve Davis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Davis		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
17. INFORMANT ADDRESS Ella Staton-Elkton, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) epidermoid carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo.		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 6/20 19 79 to 3/10 19 85 , that (I) (we) saw the deceased alive on 3/10 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Kenneth Lewis MD		
22c. DATE SIGNED 3/12/85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth Lewis MD		22e. ADDRESS Middletown Dc1		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/14/85		23c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Cecilton, Md.		24. FUNERAL DIRECTOR NAME ADDRESS Gec Funeral Home, P.A. Elkton, Md.		25a. DATE REC'D. BY REGISTRAR MAR 21 1985		
25b. REGISTRAR'S SIGNATURE John Borden Riddle						

MEDICAL CERTIFICATION



082068

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 3 8 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ruth Myrtle Davis			2a. DATE OF DEATH MONTH DAY YEAR March 4 1985		2b. HOUR 1905M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 28, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balt. Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.		13b. COUNTY Cecil	13c. CITY OR TOWN North East	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1 Jamestown Ct. 21901
14. FATHER'S NAME FIRST MIDDLE LAST Albert Biddison		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Myrtle Stiffler		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 219-18-5728		17. INFORMANT Robert G. Davis		ADDRESS Jamestown Ct. North East, Md. 21901	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Heart failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b) Coronary artery disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Acute paracetitis

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 3, 1985, to March 4, 1985, that (I) (we) lost saw the deceased alive on March 4, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. P. Caldwell		DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-7-85	23c. NAME OF CEMETERY OR CREMATORY Harford Mem. Gdns.	23d. LOCATION CITY OR TOWN COUNTY STATE Aldino Harford Md.
24. FUNERAL DIRECTOR Crouch Funeral Home		25a. DATE REC'D. BY REGISTRAR MAR 6 1985	25b. REGISTRAR'S SIGNATURE John Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 3 8 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT F. DVORAK, SR.			7a. DATE OF DEATH MONTH DAY YEAR MARCH 11, 1985		7b. HOUR a.m.
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR MARCH 31, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.		
10 CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed Farmer		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2745 Slingerly Road 21921	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph P. Dvorak		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna - Svoboda			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-36-8087A		17 INFORMANT ADDRESS Mrs. Mary Dvorak, Elkton, Md. 21921	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Empty Stomach DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-76 to 3-11-85 , that I saw the deceased alive on 3-11-85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Joseph G. Lanzi		DEGREE M.D.		22c. DATE SIGNED 3-12-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph G. Lanzi, M.D.		22e. ADDRESS 721 Bridge Street, Elkton, Md. 21921			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-14-85		23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception Cemetery, Cherry Hill, Md.	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE MAR 18 1985 Davidson-Randall			
24 FUNERAL DIRECTOR HICKS HOME FOR FUNERALS		ADDRESS ELKTON, MD. 21921		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 18 1985 Davidson-Randall	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 3 9 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DULCIE M. FENCIL			2a. DATE OF DEATH MONTH DAY YEAR MARCH 14, 1985		2b. HOUR 6:30A M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MAY 4, 1907	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH CECIL COUNTY MD.		
10. CITY OR TOWN OF DEATH RISING SUN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CALVERT MANOR NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY HARFORD	13c. CITY OR TOWN HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 703 EARLTON ROAD 21078	
14. FATHER'S NAME FIRST MIDDLE LAST EPHRAIM WOLFE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RACHAEL HOOVER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 234 12 9671		17. INFORMANT ADDRESS LEON R. FENCIL SAME AS #13e	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

(b) Diabetes Mellitus

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1957, 19, to 3/14, 1985, that (I) (we) last saw the deceased alive on 3/14, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dudley Phillips		DEGREE M.D.		22c. DATE SIGNED 15MARCH85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DUDLEY PHILLIPS, M.D.		22e. ADDRESS MASONIC BUILDING, DARLINGTON, MD.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 18MARCH85	23c. NAME OF CEMETERY OR CREMATORY UPSHUR MEMORIAL PARK	23d. LOCATION CITY OR TOWN COUNTY STATE BUCKHANNON, UPSHUR CO., WEST VIRGINIA
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078			25a. DATE REC'D. BY REGISTRAR MAR 18 1985

REGISTRAR'S SIGNATURE
Wardson-Rendell

Congestive Heart Failure

Diabetes Mellitus

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 3 9 1

099160

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARLAN B. FERRILL			2a. DATE OF DEATH MONTH DAY YEAR MARCH 29, 1985		2b. HOUR 11:55P M
3. SEX Male	4. RACE Caucasion	5. DATE OF BIRTH MONTH DAY YEAR Sept. 28, 1916	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.		
10. CITY OR TOWN OF DEATH PERRY POINT, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY I.B.M.		
13a. STATE Virginia		13b. COUNTY Fairfax	13c. CITY OR TOWN Alexandria	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Claude Ferrill		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Baird		16. STREET ADDRESS / ZIP CODE 6125 Edgewood Terrace 99999	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWTP Korean 400-54-8021		17. INFORMANT ADDRESS Janet T. Ferrill 6125 Edgewood Terrace	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

ALZHEIMER'S DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 28, 19 80, to MARCH 29, 19 85, that (we) (we) lost saw the deceased alive on MARCH 29, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE DILIP S. KITTUR, M.D.	22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT) DILIP S. KITTUR, M.D.
22e. ADDRESS VA MEDICAL CENTER, PERRY POINT, MD.		22f. DATE SIGNED	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4-2-85	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va.
24. FUNERAL DIRECTOR NAME Everly Wheatley Funeral Home, Alexandria, Va.		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 03 1985	



087137

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 3 9 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Heled. M.C. Flint</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3/20/85</i>		2b. HOUR <i>400</i> M
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 30, 1902</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penna.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil Co</i> MD	
10. CITY OR TOWN OF DEATH <i>ELKTON</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Del.</i>	13b. COUNTY <i>New Castle</i>	13c. CITY OR TOWN <i>Newark</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>610 Thompson Station Rd.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>James McVicker</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Mullen</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>221-50-4382</i>		17. INFORMANT <i>Austin C. Flint</i>	
				ADDRESS <i>New York, N.Y.</i> <i>600 W. 115th St</i> <i>10025</i>	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *CARDIOVASCULAR ARREST*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) *CEREBRAL EMBOLUS*

DUE TO, OR AS A CONSEQUENCE OF

(c) *ARTERIOCLEROTIC HEART DISEASE*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>SEP 1984</i> to <i>3/19</i> 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>3/19</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Dary Beste</i>	DEGREE <i>M.D.</i>	22c. DATE SIGNED <i>3/19/85</i>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dary Beste</i>		22d. ADDRESS <i>Newark Del</i> <i>132 West Main St.</i> <i>19711</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>3/23/85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Head of Christiana</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Newark, New Castle, Del.</i>
24. FUNERAL DIRECTOR NAME <i>RT JONES FUNERAL HOME</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 26 1985</i>	25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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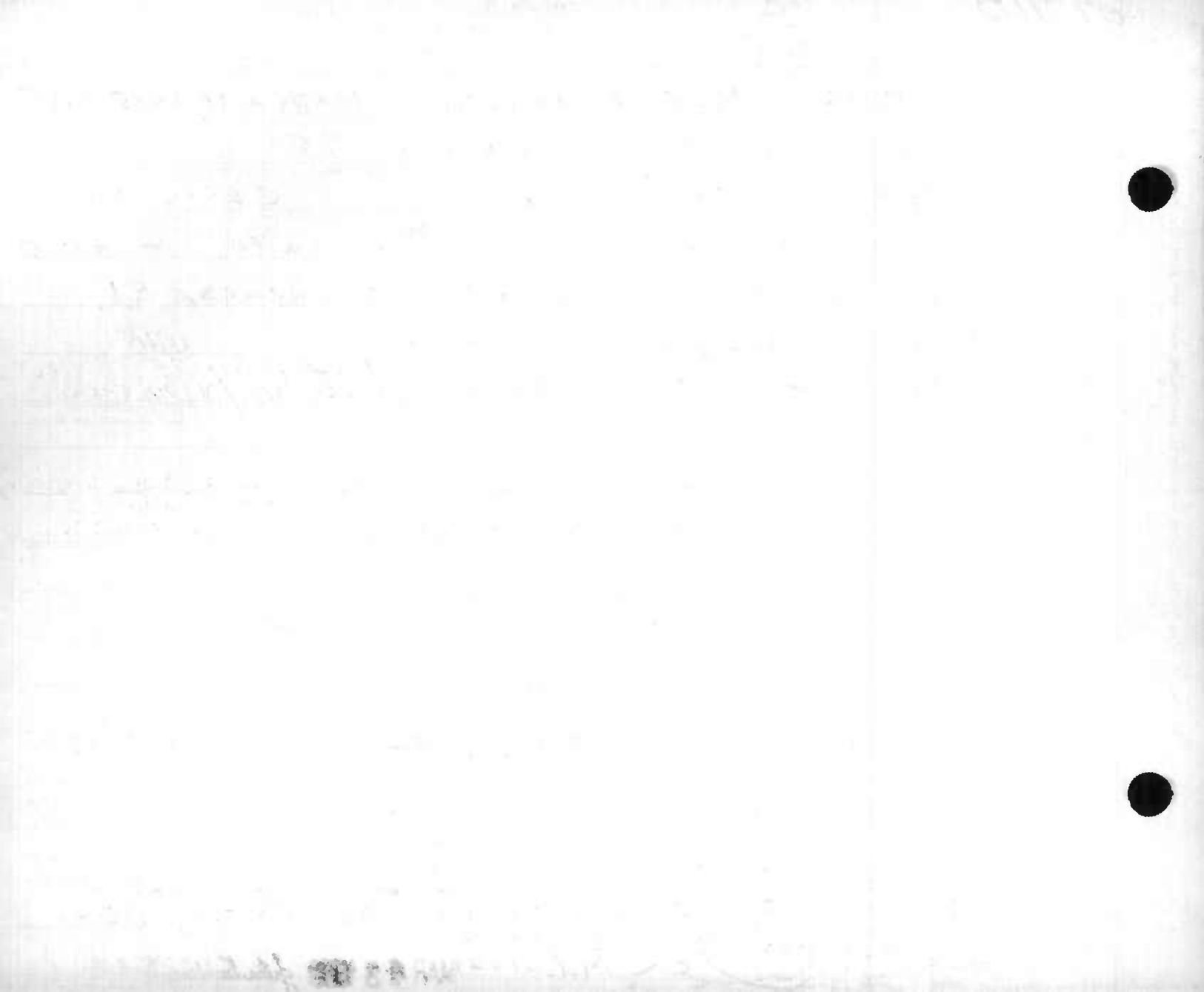
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) ODA MAE FRANKLIN			2a DATE OF DEATH MONTH DAY YEAR MARCH 11 1985		2b HOUR 3:45 PM
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR SEPT. 5, 1909		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENN.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CECIL Co. MD.	
10 CITY OR TOWN OF DEATH ELKTON	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEVINE HAVEN NURSING HOME		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b KIND OF BUSINESS OR INDUSTRY AT HOME	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE DEL			13b COUNTY NEW CASTLE	13c CITY OR TOWN NEW CASTLE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST JOHN SHUMAKE			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADA UNA		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17 INFORMANT ADDRESS RD #0 Box 75 DEC CAROLYN SHALLCROSS / MIDDLETON, DE.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>old CVA. ACVD. can't prevent (stroke mostly) with metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pericarditis (chronic) Organic Brain Syndrome</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>9/8</u> 19 <u>82</u> to <u>3/11</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>2/20</u> 19 <u>85</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>W Z H</u>		DEGREE MD		22c DATE SIGNED 3/12/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Jui Chih Hsu		22e ADDRESS 223 West Main St. Coe. Md 21921			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 3/14/85	23c NAME OF CEMETERY OR CREMATORY GRACE LANE		23d LOCATION CITY OR TOWN COUNTY STATE NEW CASTLE DEL.
24 FUNERAL DIRECTOR NAME GEE FUNERAL HOME		ADDRESS ELKTON		25a DATE REC'D BY REGISTRAR MAR 13 1985	
				25b REGISTRAR'S SIGNATURE John Franklin Ruppel	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



094071

1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 3 9 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James W. Gee			2a. DATE OF DEATH MONTH DAY YEAR March 20, 1985			2b. HOUR 4:36A M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR April 23, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Perry Point CECIL CO. MD.			
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE District of Columbia			13b. COUNTY Washington		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 324 36th Street, N.E. 99999		
14. FATHER'S NAME FIRST MIDDLE LAST Limas Gee			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Canarie Malloy						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 251 24 3319		17. INFORMANT ADDRESS Eddie Gee-wife-324 36th Street, N.E. Washington, D.C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Aortic Aneurysm-Syphilitic DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 5, 1985, to March 20, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased on March 20, 1985, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.									
22b. SIGNATURE Prem Lal, M.D.			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3-20-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PREM LAL, M.D.			22e. ADDRESS VA Medical Center, Perry Point, MD 21902						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 25, 1985		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park Landover, Md		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME 4001 Benning Road, N.E. Stewart Funeral Home, Washington, D.C.									

Handwritten notes and a large circular diagram, possibly a map or a technical drawing, are visible. The text is mostly illegible due to fading and bleed-through from the reverse side of the page.

3-20-82

100660

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMM - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8395

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ruth Gentry			2a. DATE OF DEATH MONTH 3 DAY 30 YEAR 85			2b. HOUR 3 40 P.M.						
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH Nov. DAY 7 YEAR 1901		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lake Valley, N.C.			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.			
10 CITY OR TOWN OF DEATH ELKTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LAURELWOOD NURSING CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY --			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 100 Laurel Drive 21921			
14. FATHER'S NAME FIRST Al MIDDLE -- LAST Irwin			15. MOTHER'S MAIDEN NAME FIRST Emmaline MIDDLE -- LAST Edwards			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 219-54-3128		17 INFORMANT ADDRESS Baltimore, Md. 21220 Mrs. Emma L. Spurlin, 2234 Coralhorn Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) cancer of Bronch Eritation DUE TO, OR AS A CONSEQUENCE OF (c) -- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Pulmonary Emboli, Congestive Heart Failure												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Charles H. Meyer						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 30 mar 85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 1, 1985		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Gardens			23d. LOCATION CITY OR TOWN Baltimore COUNTY -- STATE Md.				
24. FUNERAL DIRECTOR NAME Howard K. McComas III ADDRESS Abingdon, Md. 21009						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE John L. ...			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) GEORGE M. GONCE		2a. DATE KNOWN OF DEATH MONTH 3 DAY 13 YEAR 1985		2b. HOUR 3:35	
3. SEX M	4. RACE CAO.	5. DATE OF BIRTH MONTH 06 DAY 09 YEAR 11	6. AGE (IN YEARS) LAST BIRTHDAY 73 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10. CITY OR TOWN OF DEATH CECIL COUNTY		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSPITAL CECIL COUNTY		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	
12b. KIND OF BUSINESS OR INDUSTRY Electrician		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil			
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD		13b. COUNTY CECIL		13c. CITY OR TOWN ELKTON	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RT. 7. BELLOS APT. 2192			
14. FATHER'S NAME FIRST UNKNOWN MIDDLE Thomas LAST Gonce			15. MOTHER'S MAIDEN NAME FIRST UNKNOWN MIDDLE Lena LAST Wehirlow		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. 219-01-7326		17. INFORMANT George Gonce	
				17. ADDRESS 109 Bywood Rd. Elkton, Md. 21921	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
N/A

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE **Reginald W. Stallings M.D.** TITLE (SPECIFY) _____ M.D. _____ MEDICAL EXAMINER DATE SIGNED **3/13/85**

EXAMINER'S NAME (TYPE OR PRINT) _____ ADDRESS _____

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-15-85		23c. NAME OF CEMETERY OR CREMATORY North East Meth. Cem.		23d. LOCATION CITY OR TOWN North East Cecil Md. COUNTY STATE 	
24. FUNERAL DIRECTOR NAME Funeral Home North East, Md. ADDRESS 				25a. DATE REC'D BY REGISTRAR MAR 15 1985 REGISTRAR'S SIGNATURE 			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH-17
(VR 415 ME (5))

07901



RECEIVED

080042

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 3 9 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph R. Grant			2a. DATE OF DEATH MONTH DAY YEAR March 15, 1985			2b. HOUR 11:30a					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 21, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN) Cherry Hill, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.					
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, Perry Point, Md.				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Self-Employed		12b. KIND OF BUSINESS OR INDUSTRY Funeral Dir.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 102 Mill Lane 21901		
14. FATHER'S NAME Clark S. Grant				15. MOTHER'S MAIDEN NAME Mary Adelaide Work							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		17. INFORMANT 102 Mill Lane Lucia Demond North East, Md. 21901						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c: <u>Right broncho-pneumonia</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from <u>March 11, 1985</u> , to <u>March 15, 1985</u> , that (b) (we) lost <u>the deceased</u> above, (c) (we) view the body after death.											
22b. SIGNATURE <u>Klaus H. Huebner</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3-15-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KLAUS H. HUEBNER, M.D.						22e. ADDRESS VAMC, Perry Point, Md. 21902					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE 3-18-85		23c. NAME OF CEMETERY OR CREMATORY North East Meth.			23d. LOCATION North East Cecil Md. STATE			
24. FUNERAL DIRECTOR Couch Funeral Home						25. DATE REC'D. BY REGISTRAR MAR 19 1985			25b. REGISTRAR'S SIGNATURE <u>Chia Davidson-Randall</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



077140

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 50M 4/83
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 3 9 8

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Gray, Bertrude F.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 6 1985</i>		2b. HOUR <i>10 PM</i>
3. SEX <i>F.</i>	4. RACE <i>CAUCASIAN</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9 9 1878</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil MD.</i>	
10. CITY OR TOWN OF DEATH <i>Calvert, Md.</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Calvert Manor Nursing Home, Inc.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Pennsylvania</i>		13b. COUNTY <i>Chester</i>	13c. CITY OR TOWN <i>Oxford</i>	13d. STREET ADDRESS / ZIP CODE <i>603 Waterway Road 19363</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>George W. Foster</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth Pullen</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>160-07-0749</i>		17. INFORMANT ADDRESS <i>Clifford Gray 603 Waterway Oxford, Pa.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD, CAD</i> DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>diverticulosis, senility</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs</i> <i>several years</i>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>Jan 85</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>133 LOCUST ST. OXFORD, PA 19363</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 85</i> to <i>Mar 6 85</i> , that (I) (we) lost saw the deceased alive on <i>Mar 6 85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <i>Faye R. Doyle M.D.</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>3-6-85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>FAYE R. DOYLE M.D.</i>		22e. ADDRESS <i>133 LOCUST ST. OXFORD, PA 19363</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/9/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Salem United Methem Newark new Castle Del.</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Newark new Castle Del.</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>Richard L. Zookie Rising Sun, Md.</i>			
25. DATE REC'D. BY REGISTRAR <i>MAR 15 1985</i>		26. REGISTRAR'S SIGNATURE <i>Gloria Swanson</i>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

MEDICAL CERTIFICATION

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081146

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 3 9 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles Roy Guibeson			2a. DATE OF DEATH MONTH 3 DAY 15 YEAR 85		2b. HOUR 2 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 11 DAY 01 YEAR 15		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Elk Mills, Md	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Rising Sun	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto Worker		12b. KIND OF BUSINESS OR INDUSTRY AUTO.
13a. STATE Maryland		13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST James MIDDLE Henry LAST Guibeson		15. MOTHER'S MAIDEN NAME FIRST Missouri MIDDLE TOPP LAST TOPP		13e. STREET ADDRESS / ZIP CODE 100 Norman Allen St. 2A21	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-28-1455		17. INFORMANT LOIS PODY ADDRESS CALGARY ALBERTA, CANADA	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cirrhosis of liver

DUE TO, OR AS A CONSEQUENCE OF

(b)

Alcoholism

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ AT WORK NOT WHILE ☐ AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from **7**, 19 **81**, to **3**, 19 **85**, that (I) (we) last
saw the deceased alive on **3/11**, 19 **85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. **3/13/85 - 2 AM**

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

James R. Dearworth, M.D.ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐**3/15/85**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

James R. Dearworth, M.D.**167 W. Main St. Newark, Del. 19711**23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DAY

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN

COUNTY STATE

24. FUNERAL DIRECTOR
NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

BURIAL**3/19/85****CHERRY HILL METH CHERRY HILL****CECIL****MD.****Donna Ann Guibeson****ELKTON, MD.****MAR 20 1985****San Fernando Rodriguez**

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is left blank, injury, or other traumatic event, the medical examiner must be notified at once.

BP

Thyroid gland

Weight 11.01 g

61

Color

Size 1.1 x 0.8 x 0.4

Location of lesion

Location of lesion

Location of lesion

Location of lesion

Location of lesion

X



0.1 g

Location of lesion

Location of lesion

Location of lesion

Location of lesion

Location of lesion

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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3
1- FOR
STATE
REGISTRAR

REG. NO.

098028

1. DECEASED NAME (TYPE OR PRINT) <i>Laura Mae Harrigan</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3/28/85</i>		2b. HOUR <i>0350M</i>
3. SEX <i>Female</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>5-9-1888</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>96</i> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD.	
10. CITY OR TOWN OF DEATH <i>Elkton</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Devine Haven Conv. Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Delaware</i>			13b. COUNTY <i>New Castle</i>	13c. CITY OR TOWN <i>Bear</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Harry - Malin</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sarah - Foreacre</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>212-26-6478</i>		17. INFORMANT ADDRESS <i>Mrs. Florence L. Dawson, Bear, Del. 19701</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>with some psych</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Over 1 yr</i>
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>12-1-82</i> , 19 <i>82</i> , to <i>3-28</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3-27</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			

21a. SIGNATURE <i>[Signature]</i>	DEGREE <i>M.D.</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>3/28/85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>S. RALPH ANDERSON M.D.</i>		22e. ADDRESS <i>2335 Main St. Elkton, Md 21921</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>3-30-85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cherry Hill Meth. Cemetery, Cherry Hill, Md.</i>	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME <i>Ralph E. Hicks</i> ADDRESS <i>HICKS HOME FOR FUNERALS, ELKTON, MD. 21921</i>		25. DATE REC'D. BY REGISTRAR <i>APR 2 1985</i> REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If not, it may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 4 0 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KENNETH W. HARRISON			2a. DATE OF DEATH MONTH DAY YEAR March 28, 1985		2b. HOUR M AM
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 11 9 26	6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.		
10. CITY OR TOWN OF DEATH Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) repairman	12b. KIND OF BUSINESS OR INDUSTRY shipping	
13a. STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN - -	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2506 Virginia Ave. 21227
14. FATHER'S NAME FIRST MIDDLE LAST Robert W. Harrison		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helene C... Lafay			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WWII 213 20 9882		17. INFORMANT ADDRESS Helen Smullin (same as 13E)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Aspiration with cardi-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 12, 1985 to March 28, 1985 , that (I) (we) lost saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Louise U. Sultan, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3-29-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louise U. Sultan		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 4/1/85	23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Md.		
24. FUNERAL DIRECTOR NAME Gonce Funeral Home		24b. ADDRESS 4001 Ritchie Hwy, Balto. Md.		25a. DATE REC'D. BY REGISTRAR APR 2 - 1985	25b. REGISTRAR'S SIGNATURE Louise U. Sultan

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner may be called to the scene.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 5 0 8 4 0 2	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Harvey Hoelscher		MONTH DAY YEAR 3 15 85		6 45 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		
male	Caucasian	MONTH DAY YEAR 02 10 03	82 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Canada	USA		Cecil MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Elkton	Laurelwood Nsg. Cntr.	seaman	Merchant Mar.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS		
MD	Cecil		Crothers Mkt. 21904		
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		17. INFORMANT ADDRESS		
no info.	no info.		197 Hopewell Rd. Rising Sun, Md.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
unknown	231-05-8077	John Majeris			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm, Ruptured</u> DUE TO, OR AS A CONSEQUENCE OF <u>Embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dissecting Aortic Aneurysm - Ruptured</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dissecting Aortic Aneurysm - Ruptured</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/7</u> 19 <u>85</u> to <u>3/15</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/15</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
<u>John S. Lange</u>	MD		3/15/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Removal	3/15/85				
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
Anatomy Board	Balto., Md.	MAR 20 1985	John Davidson		

BP

Printed in U.S.A.

CHIEF

NOTION COLLECTION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 4 0 3

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Herman C Hurlock</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3/27/85</i>			2b. HOUR <i>1019 A_M</i>				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Apr. 17 1911</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i>		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North East, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil Co</i> MD.				
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Auto Worker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Ind.</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Md.</i>			13b. <i>Cecil</i>		13c. <i>Elkton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Unknown</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie Strimel</i>			13e. STREET ADDRESS / ZIP CODE <i>Singerly Rd. 21921</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <i>WW II 173-07-3097</i>		17. INFORMANT ADDRESS <i>Herman C. Hurlock Jr. 11732 Dayton Ave Seattle, Wash.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured thoracic aneurysm</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Thoracic Aneurysm</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>2.3 days</i> <i>2.3 days</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
21g. I certify that (1) (this hospital) attended the deceased from <i>Dec 8</i> 19 <i>83</i> to <i>March 26</i> 19 <i>85</i> , that (1) (we) lost saw the deceased alive on <i>March 26</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.										
22a. SIGNATURE <i>Satoshi Ikeda</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>3/29/85</i>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Satoshi Ikeda MD</i>			22e. ADDRESS <i>Wilmington, Del</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>4-1-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>North East Meth.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>North East Cecil Md.</i>			
24. FUNERAL DIRECTOR <i>North East Funeral Home</i>						25. DATE REC'D. BY REGISTRAR <i>APR 2 1985</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

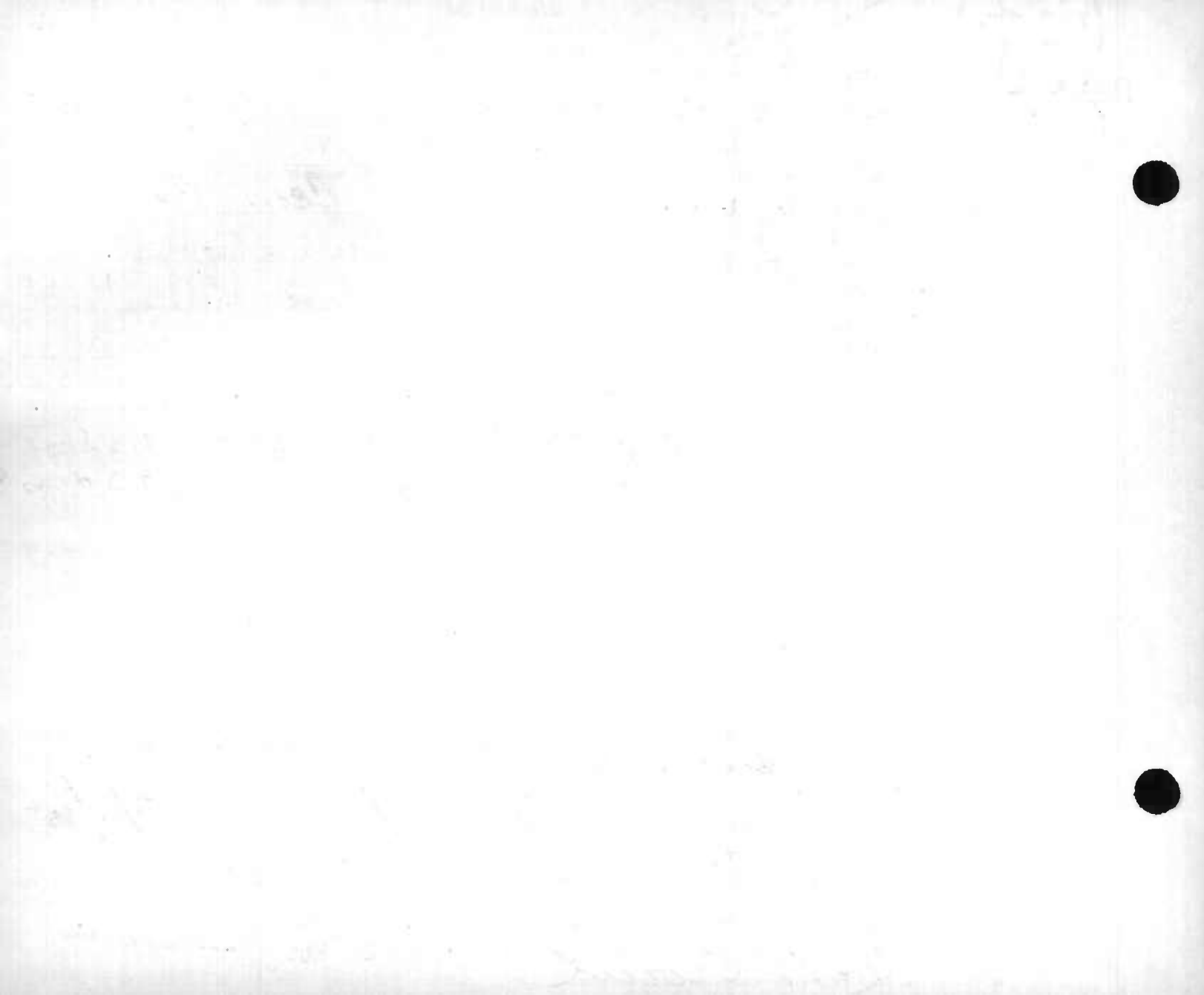
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Page 4 may be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 4 0 4

FOR
1. STATE
REGISTRAR

REG. NO.

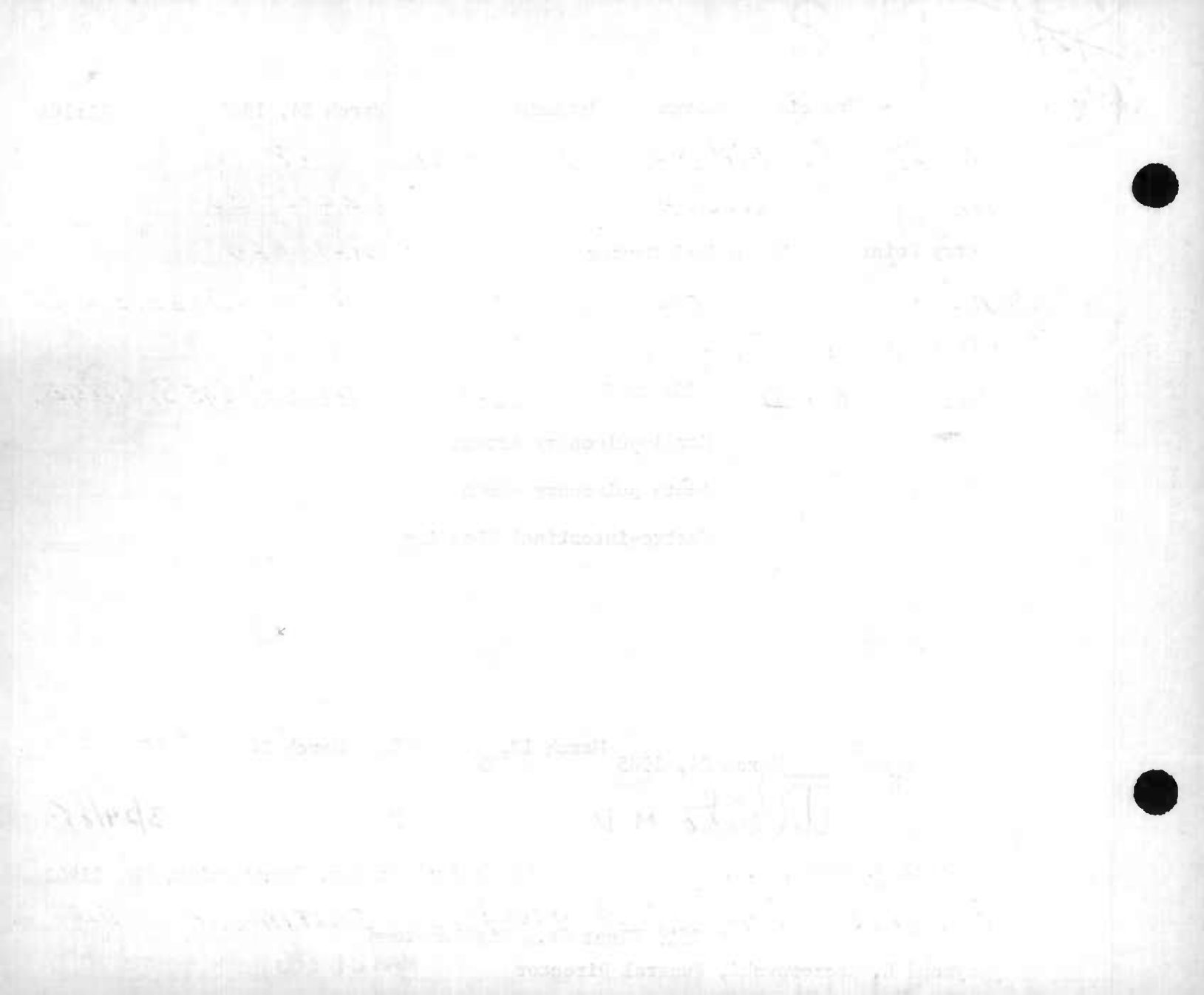
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Francis Andrew Iwancio			2a. DATE OF DEATH MONTH DAY YEAR March 24, 1985		2b. HOUR 11:18 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 12 12 1926		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL Co MD.	
10. CITY OR TOWN OF DEATH Perry Point	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS - ZIP CODE 645 S. STREEPER ST 21224	
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL IWANCIO		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA DIAKOW			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR DATES) 219 20 7863		17. INFORMANT ADDRESS HELEN WISNIEWSKI 645 S. STREEPER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Gastro-intestinal bleeding					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 13, 1985 , to March 24, 1985 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on March 24, 1985 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE Angel O. Vento, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/24/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Angel O. Vento, M.D.		22e. ADDRESS VA Medical Center, Perry Point, MD 21902			
23a. BURIAL, CREMATION, REMOVAL (CFY) BURIAL	23b. DATE 3/28/1985	23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.	
24. FUNERAL DIRECTOR NAME Raymond L. Kaczorowski, Funeral Director		25. ADDRESS 2525 Fleet St., Highlandtown		26. BY REGISTRAR 27. REGISTRAR'S SIGNATURE MAR 26 1985	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



087091

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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8405

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Esther M. Kempa			2a. DATE OF DEATH MONTH DAY YEAR 03 15, 85		2b. HOUR 1915M
3. SEX female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 29 97		6. AGE (IN YEARS LAST BIRTHDAY) 87Y	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> / NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. MD.	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil Co		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk- Lyon's Pharmacy		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md			13b. CITY Cecil	13c. CITY OR TOWN Rising Sun	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Edwin Knight			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgianna Stern		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-28-3928		17. INFORMANT ADDRESS Mrs. Nancy E. Johnson, Rising Sun, Md. 21911	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>15 MAR</u> , 19 <u>85</u> , to <u>15 MAR</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>15 MAR</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Alexander J Klufas</u>		DEGREE MD		22c. DATE SIGNED 19 MAR 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALEXANDER J KLUFAS, M.D.		22e. ADDRESS 9 S QUEEN ST. RISING SUN, MD 21911			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-19-85	23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Elkton, Maryland
24. FUNERAL DIRECTOR NAME <u>Raymond E. Hicks</u> ADDRESS HICKS HOME for FUNERALS, ELKTON, MD. 21921		25a. DATE REC'D. BY REGISTRAR MAR 22 1985		25b. REGISTRAR'S SIGNATURE <u>Davidson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 4 0 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CATHERINE E. KLESSIG			2a. DATE OF DEATH MONTH DAY YEAR MARCH 20, 1985		2b. HOUR P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 20, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	
14. FATHER'S NAME FIRST MIDDLE LAST George - Bullock			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida - Simpers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-70-4578		17. INFORMANT ADDRESS Mr. Edwin F. Klessig, Elkton, Md. 21921	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>6/23</u> 19 <u>73</u> , to <u>3/20</u> 19 <u>85</u> , that (1) we last saw the deceased alive on <u>3/20</u> 19 <u>85</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.					
22b. SIGNATURE <u>Jui Chih Hsu</u>		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-25-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jui Chih Hsu MD		22e. ADDRESS 223 West main st, Elkton Md 21921			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-23-85	23c. NAME OF CEMETERY OR CREMATORY Union Meth. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Union, Cecil, Maryland	
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u> HICKS HOME FOR FUNERALS, ELKTON, MD. 21921		25a. DATE REC'D. BY REGISTRAR APR 2 1985		25b. REGISTRAR'S SIGNATURE <u>James Davidson Henderson</u>	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 4 0 7

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles Famous Laird, Sr.			2a. DATE OF DEATH MONTH DAY YEAR March 14, 1985			2b. HOUR 11:45 A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 22 1917		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Logger		12b. KIND OF BUSINESS OR INDUSTRY Lumber	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Street		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel C. Laird		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Famous		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII			
16b. SOCIAL SECURITY NO. 218 05 2127		17. INFORMANT ADDRESS Hazel H. Laird, Street, Maryland 21154					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio-respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Advanced chronic obstructive pulmonary disease

DUE TO, OR AS A CONSEQUENCE OF

(c) G. I. Bleeding

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 13, 1985, to March 14, 1985, that (I) (we) last saw the deceased alive on March 14, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <input checked="" type="checkbox"/>							
22b. SIGNATURE V.K. Nellore		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-14-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. NELLORE				22e. ADDRESS VA Medical Center, Perry Point, MD 21902			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/18/85		23c. NAME OF CEMETERY OR CREMATORY Emory Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Street Harford Co., Maryland	
24. FUNERAL DIRECTOR NAME John H. Harkins, 600 Main St., Delta, PA. 1731				25a. DATE REC'D. BY REGISTRAR MAR 20 1985			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data sources, the statistical methods used, and the results of the analysis. The third part of the report is a discussion of the results and their implications. This includes a comparison of the results with previous studies and a discussion of the limitations of the study. The final part of the report is a conclusion and a list of references.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

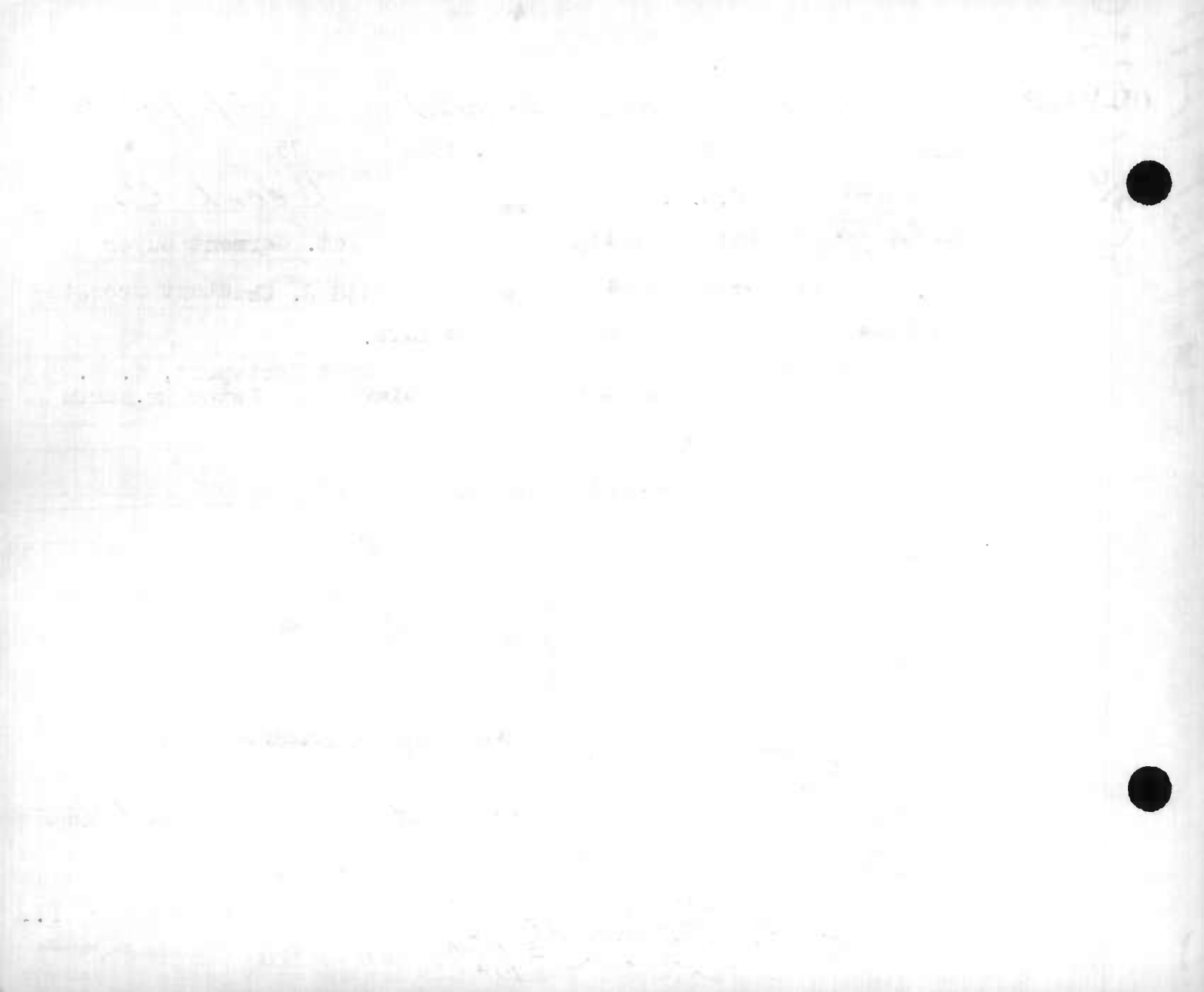
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1. FOR
STATE
REGISTRAR

REG. NO.

094029

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Esther NMI LAUSERN</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3/27/85</i>		2b. HOUR A M <i>947</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>July 27, 1909</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>75</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Denmark</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil Co</i> MD.	
10. CITY OR TOWN OF DEATH <i>EIKTON</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. Garment</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>buyer</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Del.</i>	13b. COUNTY <i>New Castle</i>	13c. CITY OR TOWN <i>Newark</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>148 E. Chestnut Crossing 99099</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Richard Laursen</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>no info.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>273-18-4801</i>	17. INFORMANT ADDRESS <i>East Northport, N. Y. Franz Oehlerich 29 Ketay Dr. North</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ASPIRATION PNEUMONIA</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>SQUAMOUS CELL CANCER OF TONGUE</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>NOVEMBER 4, 1985</i> to <i>MARCH 27, 1985</i> , that (I) (we) last saw the deceased alive on <i>MARCH 27, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.					
22b. SIGNATURE <i>Barry Barte</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/27/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DARY Beste MD</i>		22e. ADDRESS <i>Newark Del</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>	23b. DATE <i>3-28-85</i>	23c. NAME OF BURIAL OR CREMATORY <i>Cratin & Ferris</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>West Chester Chester Baa</i>	
24. FUNERAL DIRECTOR NAME <i>See Funeral Home, P.A. EIKTON, MD</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 1 1985</i>			
		25b. REGISTRAR'S SIGNATURE <i>Gene Davidson-Rondale</i>			



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 4 0 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>NINA JUNE LAWSON</u>			2a. DATE OF DEATH MONTH <u>3</u> DAY <u>12</u> YEAR <u>1985</u>		2b. HOUR <u>1740</u> M
3 SEX <u>Female</u>	4 RACE <u>White</u>	5. DATE OF BIRTH MONTH <u>April</u> DAY <u>30</u> YEAR <u>1936</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>48</u> YRS.	IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Cecil Co</u> MD.	
10 CITY OR TOWN OF DEATH <u>ELKTON</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Union Hospital</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Secretary - Schumacher Co.</u>	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <u>Maryland</u>	13b. COUNTY <u>Cecil</u>	13c. CITY OR TOWN <u>Elkton</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>602 1/2 Maryland Ave. 21921</u>	
14. FATHER'S NAME FIRST <u>Charles</u> MIDDLE <u>-</u> LAST <u>Lawson</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Louise</u> MIDDLE <u>-</u> LAST <u>Whited</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. <u>1960-63</u>		17 INFORMANT ADDRESS <u>Charles C. Lawson, Honacker, Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>OVARIAN CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>URINARY TRACT INFECTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <u></u> A.M. MONTH <u></u> DAY <u></u> YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <u></u> CITY OR TOWN <u></u> COUNTY <u></u> STATE <u></u>	
22. I certify that (I) saw the deceased on <u>4/20</u> 19 <u>83</u> to <u>3/12</u> 19 <u>85</u> , that (I) saw the deceased alive on <u>3/12</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.					
22a. SIGNATURE <u>Shashi Patel</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>3/13/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Shashi Patel MD</u>		22e. ADDRESS <u>Newark Del</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>3-16-85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ketron Memorial Gardens, Lebanon, Virginia</u>	
23d. LOCATION CITY OR TOWN <u></u> COUNTY <u></u> STATE <u></u>		24 FUNERAL DIRECTOR NAME <u>Joseph E. Hicks</u> ADDRESS <u>HICKS HOME for FUNERALS, ELKTON, MD. 21921</u>			
25a. DATE REC'D BY REGISTRAR <u>MAR 18 1985</u>		25b. REGISTRAR'S SIGNATURE <u>W. C. Henderson</u>			

MEDICAL CERTIFICATION

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Anthony J Miceika</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3/30/85</i>			2b. HOUR <i>1206 P</i>					
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>July 21, 1901</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i>		7. UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil Co</i> MD.					
10. CITY OR TOWN OF DEATH <i>ELKTON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>accountant</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>B&O R.R.</i>			
13a. STATE <i>Md.</i>			13b. COUNTY <i>Cecil Co.</i>		13c. CITY OR TOWN <i>Elkton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>70 Ash Lane 21921</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Miceika</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>-</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>705-05-3016</i>	
17. INFORMANT ADDRESS <i>Somerville</i>				18. STREET ADDRESS / ZIP CODE <i>Robert Bump 118 Bluebird Dr. N.J. 08876</i>							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
✓ PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) *CARDIAC ARREST*

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *VALVULAR + ISCHEMIC HEART DISEASE*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *no*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED <i>WHITE</i> <input type="checkbox"/> <i>NOT WHITE</i> <input type="checkbox"/> <i>AT WORK</i> <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22. I certify that (I) (this hospital) attended the deceased from *1901* to *1985*, that (I) (we) last saw the deceased alive on *March 29, 1985* and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If the doctor did not view the body after death)

22a. SIGNATURE <i>Philip P. Ruck</i> DEGREE		22b. DATE SIGNED <i>4/4/85</i>	
22c. PHYSICIAN'S NAME <i>Philip P. Ruck</i>		22d. ADDRESS <i>ELKTON, Md 21921</i>	
22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4/2/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Leonard J. Ruck, Inc. 5305 Harford Rd. 21214</i>				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>APR 8 1985</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as being a shipwreck, injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "N/A", it should be noted above the medical certification section.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) PAUL R MONDAY			2a. DATE OF DEATH MONTH DAY YEAR MARCH 17, 1985		2b. HOUR 10:15A _M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 18, 1923	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County, MD.		
10. CITY OR TOWN OF DEATH Perry Point	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER PERRY POINT MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Land Surveyor		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE 1 IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Wheaton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12709 Holdridge Rd. 20906
14. FATHER'S NAME FIRST MIDDLE LAST Wilbur Marion Monday		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lonia Robertson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT ADDRESS Margaret P. Monday, Item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) C OF LARYNX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 31, 1985, to MARCH 17, 1985, that (I) (we) last saw the deceased alive on MARCH 17, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D.S.K. H.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/17/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DILIP S. KITTUR		22e. ADDRESS VA MEDICAL CENTER PERRY POINT MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 20, 1985		23c. NAME OF CEMETERY OR CREMATORY Parklawn	
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montgomery, Md.		24. FUNERAL DIRECTOR NAME ADDRESS MOLESWORTH FUNERAL HOME 26401 RIDGE RD MD			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE MAR 20 1985 John T. ...			

DOI: 10.1002/for

1. The first part of the document discusses the importance of maintaining accurate records of all transactions.

10. *Chlorophyll a* and *Chlorophyll b* content

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1 - STATE
REGISTRAR

REG. NO.

093059

1 DECEASED NAME (TYPE OR PRINT) Annie Cleme Nelson			2a. DATE OF DEATH MONTH DAY YEAR March 21, 1985			2b. HOUR 12:15P _M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02/05/04		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10 CITY OR TOWN OF DEATH Rising Sun, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home, Inc.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Edgewood Arsenal	
13a. STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST John Cicero Dockery			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Drucie Reedy			13e STREET ADDRESS / ZIP CODE 2214 Conowingo Rd., Bel Air Md. 21014			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b SOCIAL SECURITY NO. 216-01-1653		17. INFORMANT ADDRESS Ernest Nelson, 126 Sunrise Dr., Rising Sun Md. 21911				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>senescent arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>non smoker</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk. 5 yrs.	
								PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , <u>1980</u> , to <u>3-21</u> , <u>1985</u> , that (I) (we) last saw the deceased alive on <u>3-21</u> , <u>1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Neil Taylor MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c DATE SIGNED <u>3-21-85</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Neil Taylor MD</u>				22e ADDRESS <u>Rising Sun, Md.</u>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 25, 1985		23c NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gdns		23d LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford, Maryland			
24 FUNERAL DIRECTOR Tarring Funeral Home, P.A., Aberdeen, MD, 21001-330									
25a DATE RECD BY REGISTRAR <u>MAR 27 1985</u> <u>Julia Davidson-Randall</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

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WILLIAM

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NOTION

FOR NAME

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN F. NOEL			2a. DATE OF DEATH MONTH DAY YEAR MARCH 5, 1985			2b. HOUR 2:20A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct 4, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH PERRY POINT, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nursing Attendant		12b. KIND OF BUSINESS OR INDUSTRY V.A.M.C.	
13a. STATE Maryland			13b. COUNTY Cecil		13c. CITY OR TOWN Perryville		13d. STREET ADDRESS / ZIP CODE 611 Otsego Street 21903		
14. FATHER'S NAME FIRST MIDDLE LAST John F. Noel Sr			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Agnes Kuhn			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes			
16b. SOCIAL SECURITY NO. 219-01-1268			17. INFORMANT ADDRESS Donald L. Noel, 104 Courtney Dr., Elkton, Md. 21921						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (X) (this hospital) attended the deceased from NOVEMBER 19, 1984, to MARCH 5, 1985, that (X) (we) lost saw the deceased alive on MARCH 5, 1985, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death.									
22b. SIGNATURE CHRISTOPHER BERCHELMANN, M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/5/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTOPHER BERCHELMANN, M.D.					22e. ADDRESS VA MEDICAL CENTER, PERRY POINT, MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 8, 1985		23c. NAME OF CEMETERY OR CREMATORY Mt. Erin Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Harford de Grace, Md.		
24. FUNERAL DIRECTOR Patterson & Son Funeral Home, Perryville, Md.					25a. DATE REC'D. BY REGISTRAR MAR 7 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret M. Pennington				2b. HOUR 2315 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 14 1921		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.				13b. COUNTY Cecil		13c. CITY OR TOWN Elkton	
14. FATHER'S NAME FIRST MIDDLE LAST Gordon Wesley Slagle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linnie Hawks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220-30-0720		17. INFORMANT ADDRESS Kenzie E. Pennington 1669 W. Pulaski Elkton, Md. 21921			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Resp Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Metastatic CA of Lung Seizure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>disorder 2nd to Brain mets</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Mrs. Sander</u> MD				22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
22e. ADDRESS				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-12-85		23c. NAME OF CEMETERY OR CREMATORY Lawncroft Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Linwood Chester Pa.	
24. FUNERAL DIRECTOR <u>North East Funeral Home North East, Md.</u>				25a. DATE REC'D BY REGISTRAR MAR 13 1985			
25b. REGISTRAR'S SIGNATURE <u>Wanda Davidson</u>							



098194

Items #1 4/9/85 F#602 mth

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 0 8415

1. DECEASED NAME (TYPE OR PRINT) Charles (Kenneth) Poore (AKA) Kenneth Poore		2a. DATE OF DEATH MONTH <u>3</u> DAY <u>21</u> YEAR <u>85</u>		2b. HOUR <u>6:10</u> A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH <u>9</u> DAY <u>13</u> YEAR <u>1927</u>	
6. AGE (IN YEARS LAST BIRTHDAY) <u>57</u> YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		8. CITIZEN OF WHAT COUNTRY? U.S.A.	
9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.		10. CITY OR TOWN OF DEATH FLKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Union Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) State Roads		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE MD.	
13b. COUNTY Cecil		13c. CITY OR TOWN Earleville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 21919 1850 Crystal Beach Rd - Earleville		14. FATHER'S NAME FIRST Walter MIDDLE J LAST Poore, Sr.		15. MOTHER'S MAIDEN NAME FIRST Alice MIDDLE Rhoades LAST Rhoades	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-28-4937		17. INFORMANT wife ADDRESS Earleville, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED COLON CANCER DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____		22a. I certify that (I) (this hospital) attended the deceased from <u>3/14</u> 19 <u>85</u> to <u>3/21</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>3/20</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Yogish A. Patel DEGREE _____	
22c. DATE SIGNED <u>3/22/85</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Yogish A Patel MD		22e. ADDRESS Newark Del	
23a. BURIAL INFORMATION, REMOVAL (SPECIFY) Burial		23b. DATE <u>3/24/85</u>		23c. NAME OF CEMETERY OR CREMATORY Lion Cemetery	
23d. LOCATION CITY OR TOWN Cecil COUNTY Cecil STATE MD.		24. FUNERAL DIRECTOR NAME Fellows Funeral Home ADDRESS Millington, Md. 21651		25a. DATE REC'D. BY REGISTRAR APR 1 1985	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show only injury, or other traumatic event, the medical examiner must be notified and a copy of the report filed with the State Dept. of Health and Mental Hygiene.

BP _____

082072

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 4 1 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CATHERINE - PUMA			2a. DATE OF DEATH MONTH DAY YEAR March 6, 1985		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR December 22, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 100 Laurel Drive 21921
14. FATHER'S NAME FIRST MIDDLE LAST Joseph - Puma		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena - Lanzi			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 164-12-4100M		17. INFORMANT ADDRESS Mrs. Carol C. Lolow, Elkton, Md. 21921	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIOGENIC SHOCK**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **ACUTE MYOCARDIAL INFARCTION**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2-21, 1985 to 3-6, 1985 , that (I) (we) lost saw the deceased alive on 3-6-1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ehsanur Rahman		DEGREE MD		22c. DATE SIGNED 3/8/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EHSANUR RAHMAN		22e. ADDRESS 2102 DRUMMOND PLAZA NEWARK, DE 19711			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-9-85	23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception	23d. LOCATION CITY OR TOWN COUNTY STATE Cherry Hill, Maryland
24. FUNERAL DIRECTOR HICKS HOME FOR FUNERALS, ELKTON, MD. 21921		25a. DATE REC'D. BY REGISTRAR MAR 11 1985	25b. REGISTRAR'S SIGNATURE <i>John Davidson Hordell</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGINIA LEE ROARK			2a. DATE OF DEATH MONTH DAY YEAR MARCH 12, 1985		2b. HOUR 8:10 a.m.
3 SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 23, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William - Nelson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Jane Lewis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 218-18-5110		17. INFORMANT ADDRESS Mrs. Cassie M. Plaskon, Bensonville, Ill. 60106	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension, ASCVD, Cardiac Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic disease of femoral artery</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from <u>10/24</u> 19 <u>72</u> , to <u>3/12</u> 19 <u>85</u> , that (b) (we) lost saw the deceased alive on <u>3/12</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (c) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>Jui Chih Hsu</u>		DEGREE MD		22c. DATE SIGNED 3-13-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jui Chih Hsu		22e. ADDRESS 223 West main st. Elkton Md 21921			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-15-85		23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial	
23d. LOCATION CITY OR TOWN COUNTY STATE Elkton, Md. 21921		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE MAR 18 1985 <u>Julia David</u>			
24. FUNERAL DIRECTOR HICKS HOME FOR FUNERALS, ELKTON, MD. 21921					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

093056

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WINIFRED SAVAGE			2a. DATE OF DEATH MONTH DAY YEAR MARCH 20, 1985		2b. HOUR 6:53A		
3. SEX Female		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 6 20 1902		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Massey Elkhart		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSP. OF CECIL CO.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.		13c. CITY OR TOWN Massey		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Main St. 21650	
14. FATHER'S NAME FIRST MIDDLE LAST Joshua Wilson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hanna HOWLETT		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 215-02-5937	
17. INFORMANT ADDRESS Barbara Hopper Massey		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO - PULMONARY COLLAPSE DUE TO, OR AS A CONSEQUENCE OF (b) CLINICAL MYOCARDIAL INFARTION DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES 1hr YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R.P. Denit		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/21/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.P. DENIT		22e. ADDRESS 210 MD Cecilton MD 21913					
23a. BURIAL, CREMATION, REMOVAL (IF BY F) CREMATION		23b. DATE 3/21/85		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Cee.		23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington NC Del.	
24. FUNERAL DIRECTOR NAME Fellows F.H.		ADDRESS Box 270 MILLINGTON MD		25a. DATE REC'D BY REGISTRAR MAR 27 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to the scene.

100-443887-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO. 85 08419			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH W SAVIN				2a. DATE OF DEATH MONTH DAY YEAR 3 2 85			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11 1 91		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 93	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECILIA MD.	
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NET CARTONER		12b. KIND OF BUSINESS OR INDUSTRY BUILDING	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE MD		13b. COUNTY CECILIA		13c. CITY OR TOWN CHESAPEAKE		13e. STREET ADDRESS 225 GEORGE 21915	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM THOMAS SAVIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LINDA T ROSS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-22-2371		17. INFORMANT ADDRESS ELLEN M. SAVIN CHESAPEAKE CITY MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure & Poss. M.I.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO OR AS A CONSEQUENCE OF (b) Chronic Obstr. Pul Dis. & Exacerbated							
DUE TO OR AS A CONSEQUENCE OF (c) 5/yr. Pacemaker + Diabetic Mell.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE STREET			
22a. I certify that (I) (this hospital) attended the deceased from 2/25 , 19 85 , to 3/2 , 19 85 , that (I) (we) lost saw the deceased alive on 3/1 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature] M.D.				22c. DATE SIGNED Feb. 2/85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. E. ABLANG	
22e. ADDRESS 200 POW ST ELKTON MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-5-85		23c. NAME OF CEMETERY OR CREMATORY BETHEL		23d. LOCATION CITY OR TOWN COUNTY STATE CHESAPEAKE CITY MD	
24. FUNERAL DIRECTOR NAME R.T. FOARD FUNERAL HOME CITY MD				25a. DATE REC'D. BY REGISTRAR MAR 05 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

10-11-2011

1. The first part of the report
describes the general situation
of the country and the
main problems which are
facing the government.
It also mentions the
main achievements of the
government in the past
few years.

2. The second part of the report
describes the main problems
which are facing the
government. It mentions
the main causes of these
problems and the main
consequences of these
problems.

3. The third part of the report
describes the main
recommendations of the
committee. It mentions
the main measures which
should be taken to
solve the problems
facing the government.

082071

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGE 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) James E. Schuck			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 4 1985			2b. HOUR M 955A		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR JULY 11, 1905	6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 5 1985		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.		
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 125 Overbrook Lane			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman - Empire Paper Co.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 125 Overbrook Lane 21921
14. FATHER'S NAME FIRST MIDDLE LAST Henry - Schuck				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sealy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 216-01-2258		17. INFORMANT ADDRESS Mrs. Pauline E. Schuck, Elkton, Md. 21921			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE J. Vital			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER DATE SIGNED 3-5-85		
EXAMINER'S NAME (TYPE OR PRINT) Juan C Gonzalez-Vital MD			ADDRESS Union Hospital, Elkton, MD 21921					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-8-85		23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception		23d. LOCATION CITY OR TOWN COUNTY STATE Cherry Hill, Cecil, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Hal E. Hickel				25a. DATE REC'D. BY REGISTRAR MAR 11 1985		25b. REGISTRAR'S SIGNATURE		

05-10-11

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM HERSCHEL SHIRES			2a. DATE OF DEATH MONTH DAY YEAR 3 - 28 - 85			2b. HOUR M					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 4 03		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.					
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSPITAL ELKTON				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY SAW MILL			
13a. STATE MD.			13b. COUNTY CECIL		13c. CITY OR TOWN RISING SUN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 378 WEAVERS MEADOWS RD. 21911		
14. FATHER'S NAME FIRST MIDDLE LAST HARRY SHIRES				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARLIE MAUDE SCOTT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 217-05-9246		17. INFORMANT ADDRESS GRACE M. SHIRES (SAME)					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA (Cerebral Vascular Accident) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD congestive brain syndrome		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Jui Chih Hsu				DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22e. ADDRESS 223 meet main st, Elkton Md.							

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-1-85		23c. NAME OF CEMETERY OR CREMATORY BROOKVIEW CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE RISING SUN CECIL MD.	
24. FUNERAL DIRECTOR NAME ADDRESS RT FORD FUNERAL HOME RISING SUN MD.				25a. DATE REC'D. BY REGISTRAR APR 02 1985		25b. REGISTRAR'S SIGNATURE Julia...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause of death.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO. 8 5 0 8 4 2 2

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter H. Stevens			2a DATE OF DEATH MONTH DAY YEAR March 14, 1985		2b HOUR 12:20 P.						
3 SEX Male		4 RACE White		5 DATE OF BIRTH Oct. 4, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.					
10 CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Trackman		12b KIND OF BUSINESS OR INDUSTRY Rail Road			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b CITY OR TOWN 13c STREET ADDRESS Md. Cecil North East 25 Rail Road Rd. 21901											
14 FATHER'S NAME FIRST MIDDLE LAST William Stevens				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATE) WW II 232-12-3901		17 INFORMANT Gladys Stevens		25 ADDRESS 25 Rail Road Rd. North East, Md. 21901			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular & Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) Aspiration Pneumonia

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
Cancer of Prostate Gland & Multiple Metastasis, C.O.P.D.

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>Sept 10</u> 19 <u>60</u> , to <u>March 14</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>March 14</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>Luis M. Guza M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 3-16-85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) LUIS M. GUZA M.D.				22e ADDRESS 322 E CECIL AVE NORTH EAST, M.D.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 3-18-85		23c NAME OF CEMETERY OR CREMATORY North East Meth.		23d LOCATION CITY OR TOWN COUNTY STATE North East Cecil Md.	
24 FUNERAL HOME NAME ADDRESS <u>Funeral Home North East, Md.</u>				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE <u>John T. ...</u>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 4 2 3

082073

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERALD A SULLIVAN			2a. DATE OF DEATH MONTH DAY YEAR MARCH 1 1985		2b. HOUR 10:07PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 5 1924	6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. MD.	
10. CITY OR TOWN OF DEATH Perryville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER PERRY POINT MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. STATE Md.		13b. COUNTY Cecil	13c. CITY OR TOWN Conowingo	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 471 Connley Rd. 21918
14. FATHER'S NAME FIRST MIDDLE LAST Frank Albert Sullivan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Regina Roe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 210 18 9525		17. INFORMANT ADDRESS Mrs. Bette S. Crisman, 2504 Middle Rd. Winchester, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 1 , 19 84 , to MARCH 1 , 19 85 , that (I) (we) last saw the deceased alive on MARCH 1 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Eugene A. Jaeger</i>		DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/2/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE A. JAEGER		22e. ADDRESS VA MEDICAL CENTER PERRY POINT MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/4/85	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Balto. Md.	
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD		ADDRESS BALTIMORE MD 21212		25a. DATE REC'D. BY REGISTRAR MAR 6 1985	25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>

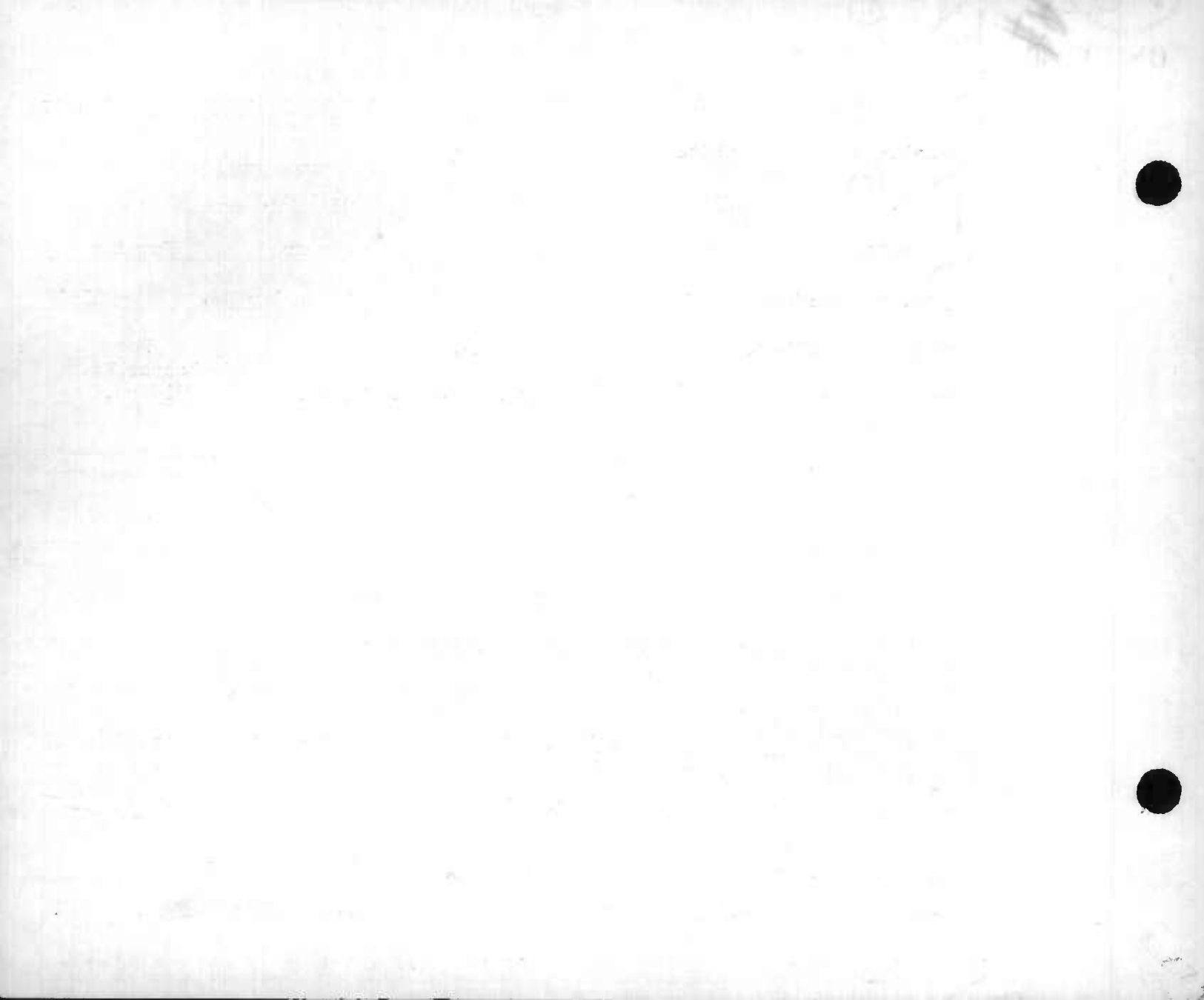
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP _____



7

20% COTTON FIBER

WILKINSON



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		8 5 0 8425	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST ANDERSON	MIDDLE N.	LAST VIARS	MONTH DAY YEAR March 5 '85
3. SEX Male		4. RACE White	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MONTH DAY YEAR JUNE 9, 1909		75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Employee- Va. State Hwy. Dept.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Cecil	
13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 150 E. Main Street 21921		14. FATHER'S NAME	
FIRST Joseph		MIDDLE -	
LAST Viars		15. MOTHER'S MAIDEN NAME	
FIRST Ellen		MIDDLE -	
LAST Gravely		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 231-18-4113		17. INFORMANT Mr. John D. Viars, Elkton, Md. 21921	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of the lung</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>March 5, 1985</u> , to <u>March 5, 1985</u> , that (I) (we) last saw the deceased alive on <u>March 5, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>R. S. Ackert</u>		22c. DATE SIGNED 3-5-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard S. Ackert, M.D.		22e. ADDRESS 221 E. Main St. Elkton, Md. 21921	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3--8-85	
23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park, Elkton, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <u>Nash E. Hicks</u> ADDRESS HICKS HOME FOR FUNERALS, ELKTON, MD. 21921		25a. DATE REC'D. BY REGISTRAR MAR 11 1985	
25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 4 2 6

1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM R. WADDELL			2a. DATE OF DEATH MONTH DAY YEAR March 6, 1985		2b. HOUR 8:25am
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 5 24 26		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.	
10. CITY OR TOWN OF DEATH Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. ELECTRONICS TECH-GOVERNMENT	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD.	13b. COUNTY CECIL	13c. CITY OR TOWN Perry Point	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 56 WAIBLE Rd 21904	
14. FATHER'S NAME FIRST MIDDLE LAST ALISON P WADDELL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA GOODMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 220-18-7240		17. INFORMANT ADDRESS ROBERT WADDELL CONOWINGO, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute hemorrhage due to ruptured esophageal varicosities DUE TO, OR AS A CONSEQUENCE OF (b) Advanced alcoholic cirrhosis of liver DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Hypertensive arteriosclerotic heart disease and type II diabetes					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (X) this hospital attended the deceased from March 5 , 19 85 , to March 6 , 19 85 , xxxxxxx and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if (we) (did) did not view the body after death.					
22b. SIGNATURE K. H. Huebner		DEGREE M.D.		22c. DATE SIGNED 3-6-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. H. HUEBNER, M.D.		22e. ADDRESS VA Medical Center, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 3-8-85	23c. NAME OF CEMETERY OR CREMATORY CONOWINGO BAPTIST CHURCH CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CECIL MD.	
24. FUNERAL DIRECTOR NAME Foard Funeral Home, Rising Sun, Md.		25. DATE RECORDED IN REGISTRAR'S SIGNATURE MAR 11 1985			

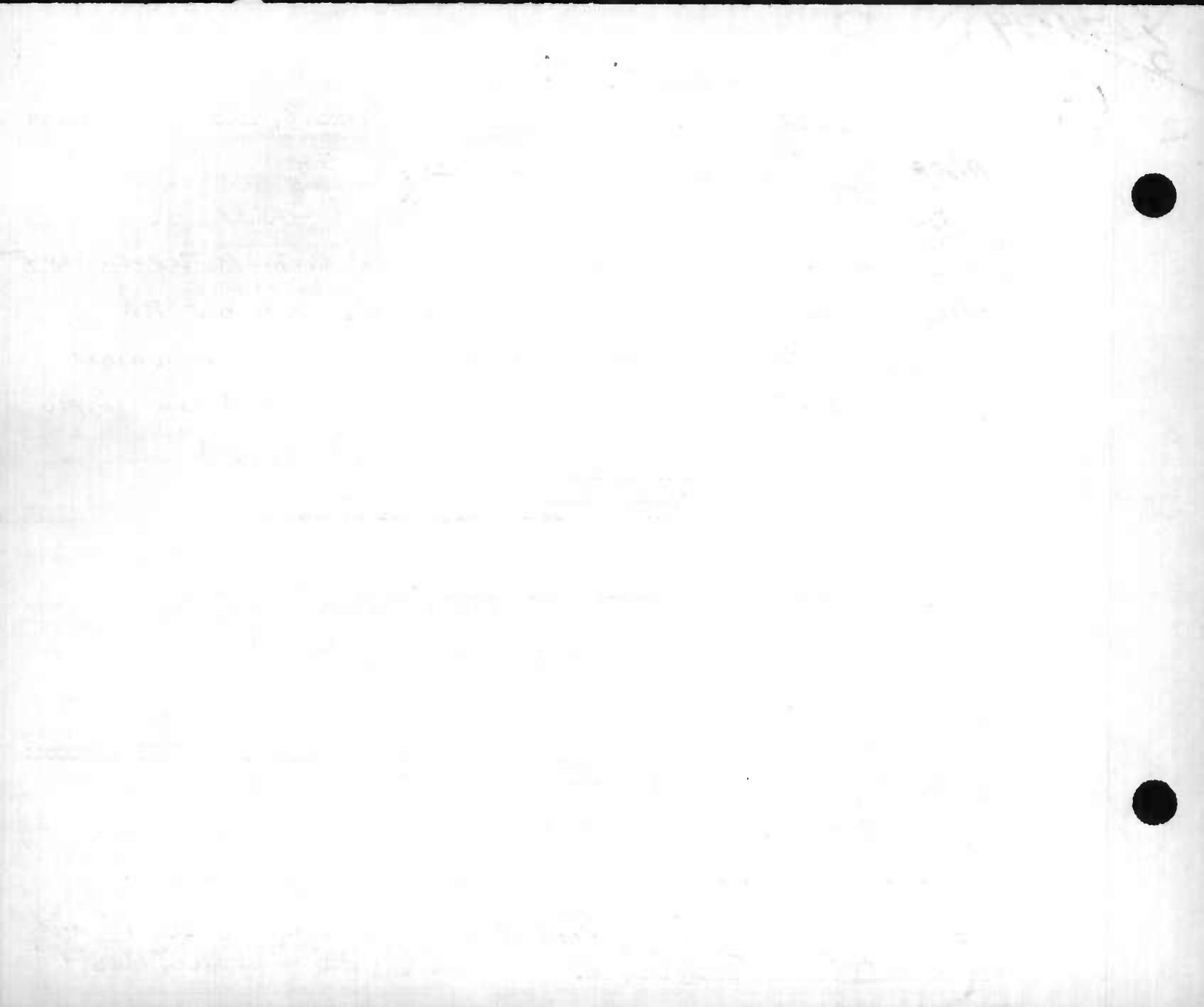
MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.



091064

B

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 08427

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edith F. West			2a. DATE OF DEATH MONTH DAY YEAR 3/21/85			2b. HOUR 1105 AM					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 28 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		6. IF UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.					
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSPITAL ELKTON				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINE OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY FIBER FRAYS			
13a. STATE DE.			13b. COUNTY NEWCASTLE		13c. CITY OR TOWN NEWARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2916 Elkton Rd.		
14. FATHER'S NAME FIRST MIDDLE LAST WILMER FOWLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADDIE REYNOLDS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 186-10-1315		17. INFORMANT WARREN WEST		ADDRESS 9 E. STEPHENS DR NEWARK DE. 19713			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CUAS</u>			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>cardiovascular heart disease</u>			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/19</u> , 19 <u>85</u> , to <u>3/21</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3/21</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joann Rosenfeld MD						22c. DATE SIGNED 3/21/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joanne Rosenfeld MD						22e. ADDRESS Cecil Co, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-23-85		23c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rising Sun Cecil Md	
24. FUNERAL DIRECTOR NAME R.T. FOARD FUNERAL HOME		ADDRESS Rising Sun		DATE REC'D. BY REGISTRAR MAR 26 1985		REGISTRAR'S SIGNATURE John Anderson	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

